

*The paradox of success and
the challenge of change:
Home birth associations of
Aotearoa/ New Zealand*

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Abstract

This thesis is a social and political analysis of the home birth associations of Aotearoa/ New Zealand. These consumer groups were formed in late 1970s and over the last twenty years have responded to significant changes in the health sector, some of which are the outcome of home birth political activism. Like many other grass roots movements attempting to achieve change, activists have constantly been challenged to re-create 'collective identities' and re-position themselves with respect to various sets of 'allies', 'opponents', and 'bystanders'. The thesis examines how home birth associations in Aotearoa/ New Zealand have responded in various ways to the radical changes in the professional status of midwifery and the restructuring of the health sector in the 1990s. This analysis draws on theorising about social movements, feminist activism, professionalising strategies and the impact of neoliberal policy projects in the health sector. Home birth association newsletters, the print media, one to one interview, focus group discussion and participant observation are used in this feminist qualitative project.

The contradictory positioning of home birth as simultaneously part of *and* marginalised within New Zealand's state funded maternity service drew home birth advocates into conflicts and compromises with the state. Activists from the home birth associations prioritised a 'rights' claim over a home birth advocacy frame and succeeded in effecting significant changes to maternity services as more choices were made available to women. This, however, has not necessarily lead to corresponding changes in the balance of power between consumers and professional experts in policy making and knowledge production. The New Zealand College of Midwives, which grew out of home birth networks, attempts to address power relations through a discourse of 'partnership'. However, the

asymmetrical dependence of home birth associations on midwives to link new members to local networks, and for activists to have a voice in policy making, creates new challenges and strains for home birth activists. A number of home birth associations have attempted to gain contracts with state health funding authorities as a means to exercise more consumer control over home birth services. This raises a new problems for activists as they renegotiate their relationships with state agencies, midwives and women choosing to birth at home.

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1

Introduction: home birth associations at the end of the millennium

Confronting the Paradox

The home birth associations in New Zealand are in a paradoxical position at the end of the millennium. On the one hand there is much to celebrate - they have achieved some marked successes. Two decades of home birth activism has led to a significant increase in home births, from 0.04% of births in 1974 to approximately 5% in 1998.¹ The alliance forged between home birth activists and home birth midwives provided a key impetus for

¹ The 1974 figure is cited in Gulbrandsen, et al, (1997:88). The 1998 figure is an estimate included in a report on maternity services produced by the National Health Committee (1999:46). In a message to the 1999 Aotearoa/ New Zealand Home Birth Associations conference, Karen Guilliland (National Director of the New Zealand College of Midwives) said that New Zealand has the second highest rate of home births of Western nations. She also suggested that the home birth rate might be as high as 7%. Official data is not being collected.

midwives to form the New Zealand College of Midwives to represent their professional interests. In recognition of the contribution made by consumer supporters of midwives, consumers are able to be members of the College and are included on the College's governing body. This was a 'first' in the world for a national midwifery professional organisation. Home birth activists' demands on the state to improve the working conditions of domiciliary midwives were realised in 1990, when the law was changed to enable midwives to attend 'normal' births without medical supervision. This change also allowed midwives to claim from the state funded maternity benefit schedule at the same rate as general practitioners (GPs) and to attend clients in hospitals. Direct-entry midwifery courses, campaigned for by home birth activists, were established to enable people to become registered as midwives without first being trained as nurses.

On the other hand, these successes pose new challenges for home birth activists. It is these challenges that are examined in this thesis. One consequence of their 'success' is that home birth associations have lost their political focus and activists face new obstacles in having an input into maternity services policy. While in the 1980s, activists demanded the right to birthing choices for all women, in the 1990s, they have encountered many women who now deploy this language of the 'right to choices' to demand different forms of birthing services. In the 1980s consumers who birthed at home and the domiciliary midwives who attended them formed mutually interdependent bonds under the conditions of shared marginalisation. This has become more complicated as midwives lay claim to a new professionalised status.

A health restructuring programme initiated a year after midwives were granted 'autonomy' has created new opportunities for home birth associations to reposition themselves as providers of state funded services. Some home birth groups have received contracts to provide antenatal

classes or postnatal home help, and two home birth groups are contracted to provide a complete maternity service, including midwifery care, for women birthing at home within their region. Other groups have entered into negotiations and have not been granted contracts from the agencies that distribute funds. Some associations have strongly opposed entering into such contracts. Many other home birth associations do not have the resources to even consider contracting.

This thesis is about the home birth movement in New Zealand. More particularly, it is about the formal organisations of the movement - a loose network of local groups called 'home birth associations'.² It investigates how home birth activists - specifically committee members interviewed in Auckland, Tauranga, Palmerston North, Wellington, Christchurch, Dunedin and Invercargill - interpret these changes and new challenges. What opportunities do they see for continued collective action? How do local contexts and differences between home birth associations 'activate' differing interpretations and strategies? What common or divergent discourses are used?

The home birth associations are not just interesting in and of themselves. They are interesting as a social movement responding to a new political environment which includes opportunities opened up by economic rationalist agendas as well as a legacy of feminist activism in the 1980s. They are also interesting because of the variety of responses amongst and within home birth groups to the challenges of the last decade. These differences are produced through the interweaving of local contexts and the specific histories of each home birth association, the selections of

² When I commenced this research I had contact addresses for 28 home birth associations. At that time, only 17 of these groups were meeting regularly. Those that were not holding meetings were all in rural areas where numbers of home births may be very small. These rural associations have always tended to be deactivated and reactivated according to interest.

discourses drawn on by the members of particular groups and through interactions between different home birth associations. This thesis explains how home birth associations negotiate multiple, shifting positions with respect to various sets of consumers, midwives, GPs that are involved in providing maternity services, obstetricians, health sector managers and politicians.

How can an inquiry into the Home Birth Associations in New Zealand generate understandings which are significant beyond the micropolitics specific to home birth activism? The home birth associations, like many other grass roots movements attempting to achieve change, are constantly pushed to re-make, re-position themselves with respect to consumers, professionals, and the state - each of these, all the time. I am interested in investigating the complexities and the paradoxes produced through negotiating this complicated web of social relations. What can investigation of home birth associations tell us about new social movements, changing political processes and power relations, the constructions of selves and knowledge production? In answering these questions I draw on the work of European social movement theorists, in particular Alberto Melucci, as well as feminist analyses of the state and social policy.

In the next two chapters I outline some of the theoretical and methodological concerns that have shaped this thesis. I argue that social movements arise out of 'contexts'. Movement 'collective action frames', or articulations of their interests, are produced by participants through conflicts with authorities and opponents, the available cultural codes that can be appropriated to justify collective action, and the interactions and debates among participants of the movement. As these contexts change, movements are challenged to reconstruct their collective action frames. A critical aspect of this 'context' with respect to birthing politics is the institutionalised effect of past policies and the struggles over creating

surrounding childbirth (Donley, 1986:81-82). While this home birth activism was part of an international movement, and these associations made contacts with home birth organisations in Australia, the United States and England, many aspects of the home birth movement in New Zealand are unique. The location of home birth as simultaneously part of the state funded maternity service in New Zealand, and, at the same time, marginalised and under threat drew home birth association activists into intense engagement with politicians, public servants and hospital boards. This also indicates the need to attend to the particular history of birthing services in New Zealand to situate the politics of home birth in the 1990s.

Chapter four begins with an account of how the state entered into regulating and providing maternity services through the state registration and training of midwives. I outline the various struggles between doctors, midwives, women and state actors through which a highly medicalised birthing service was developing. At the same time, I demonstrate the complexities of these struggles to provide a way into understanding the complexities of contemporary birthing politics. The following two chapters continue this narrative and focus on the emergence of the home birth movement and first decade of political activism by home birth associations.

Chapters seven through to eleven examine challenges for home birth activism in the 1990s. The first of these chapters looks at the unintended outcomes of the successful policy interventions that enabled midwives to practice without medical supervision. This changed the meaning of home birth from a 'political act' to another 'lifestyle' birthing option.

Just prior to regaining autonomy, midwives and their consumer supporters formed the New Zealand College of Midwives. The College has a commitment to working in 'partnership' with consumer groups. While partnership provides one avenue for consumer participation in health

policy making, its realisation is shaped by the professional power of midwives. Chapter eight considers the differences between Treaty partnership and the construction of midwives and birthing women as 'partners'. It draws on interviews with home birth activists who have represented home birth associations within the College of Midwives.

In 1991, the government restructuring of the health system made it possible for home birth associations to tender for contracts with health funding authorities. Home birth activists framed contracting as both an 'opportunity' and as a 'compromise'. The complexities of contracting for home birth associations will be discussed in chapters nine and ten.

2

Social movements, political opportunities and social change

Introduction

This chapter offers an overview of the key theoretical ideas which shape this thesis. I begin with a discussion of the aspects of collective action that social theorists consider to define a social movement and ask whether, or in what ways contemporary home birth associations can be considered a social movement. I examine what the two currents of social movement theorising - resource mobilisation and new social movement theory - have to say about the ways in which 'success' can be problematic for social movement organisations. This introduces one strand of questions that later chapters of this thesis address.

The second half of this chapter examines feminist analyses of the state and argues for the relevance of viewing 'the state' as a complex set of institutional arenas and social relations. To account for the shifting relationships between home birth associations and the state, we need to attend to the ways in which state actions can both legitimate forms of discrimination against women and be used to challenge these. In this thesis, these contradictory processes are analysed by focussing on the 'policies' that relate to maternity services and the health and social welfare sectors more generally. I outline how contemporary theorists 'theorise' policy making as an unpredictable outcome of social struggles and as profoundly programmatic in its effects. This approach is applicable not only for looking at changes in maternity services, but also for understanding the ways in which policies and policy making processes impact on the organisational forms of the home birth associations. The chapter ends with a discussion of two phrases which reappear in this thesis - 'political opportunity structures' and 'collective action frames'. I indicate how these will be used to account for the 'interventions' pursued by home birth activists as they seek to secure particular kinds of home birth services and more enduring positions for participation in policy making.

A home birth movement?

The following interchange between two long term activists in one of the group interviews conducted for this thesis provides a provocative introduction to the questions addressed in this section on social movements and success:

Celia: Because it's an available option now, what people in our society kind of do now is 'access' a service, use it and move on. Whereas we were much more politically motivated. It was *hard* to access a service. We were

very aware of the burden providing the service placed on midwives who provided the service and we were passionate about it.

Marian: We became part of a movement.

Celia: Yes.

(Auckland Home Birth Association interview, 16 June, 1997)

Discussing the changes to home birth activism, Celia contends that home birth has now become a birth 'option' in contrast to the 1980s when birthing at home entailed a political commitment. Marian remarks that home birth once was, but no longer is, a social movement.¹ My assumption during the research stage of this project was that I was studying a social movement, in particular the organisations of a movement. This raises some interesting questions: In what respects *was* the home birth association movement a 'social movement'? *Is* it still a social movement? What is interesting analytically about attending to its current form?

Contemporary theorising about social movements differentiates social movements from other, related forms of collective action. Theorists distinguish movements from more institutionalised collectivities such as interest groups, voluntary service organisations and political parties on the one hand, and from less organised forms of collective behaviour which include fashions, social trends, and short-lived public 'panics' on the other (see for example Gusfield, 1994:63; McAdam and Snow, 1997:xxi; Tarrow, 1994:2-5; Touraine, 1985:750-751). The difference between social movements and interest groups is defined by how they are positioned in relation to 'elites and authorities'. Doug McAdam and David Snow argue that:

¹ An activist who was a member of the Christchurch Home Birth Association in the early 1980s made similar comments. She suggested: "We were part of a movement that was underground ... standing up for something you passionately believe in. ... Now home birth isn't a political act' (Tilda, individual interview, Christchurch, 31 May, 1998).

Interest groups are embedded within the mainstream political environment; they are typically regarded as legitimate actors within the political arena. Social movements, on the other hand, are typically outside of the polity, or overlap with it in a precarious fashion (1997:xxi).

Movements, thus, are defined as 'typically' representing those who have no established voice within the political order (see also; Flacks, 1995:21; Howell, 1990:16-20; McAdam and Snow, 1997:1-2).

French sociologist Alain Touraine stresses that engagement in conflict is a defining aspect of social movements. He states that:

There is an almost general agreement that social movements should be conceived as a special type of social conflict. Many types of collective behaviour are not social conflicts: panics, crazes, fashions, currents of opinion, cultural innovations are not conflicts even if they define in a precise way what they react to. A conflict presupposes a clear definition of opponents or competing actors and of the resources they are fighting for or negotiating to take control of (1985:750-751).

Touraine argues that social trends, panics and changes in social practices are not social movements because these lack the 'clear definition of opponents' and the struggles for control of social resources which characterise social movements. Trends and fashions are defined as the effects of a number of individuals acting in a parallel way without apparent reference or ties to each other (see also; Gusfield, 1994:63; McAdam and Snow, 1997:xxi).

Some home birth activists from the 1970s and 1980s, who campaigned for the legitimisation of home birth and domiciliary midwives, are in the 1990s observing or working alongside women who no longer approach home birth or the associations with a strong political commitment. This new

generation of birthing women can assume access to home birth and therefore can view home birth as a 'lifestyle choice', rather than a political statement. At the same time, some home birth associations are entering into contracts with statutory agencies to deliver state funded home birth services in their local area. Does that mean that as they are seeking to reposition themselves 'inside' the polity, that they can therefore be described as an interest group? What has emerged in the 1990s are new complexities in home birth activism. Home birth associations - as support groups for people who choose a certain birth option, or as political watchdogs protecting the boundaries of home birth and ready to respond to countermobilisations, or as providers of home birth services - can no longer be easily defined as social movement organisations according to this typology. The extent to which each association focuses on one or more of these divergent organisational goals is regionally variable. This is why it is an advantage in this research to speak to people from different home birth associations.

The shift from home birth associations as social movement organisations to more hybrid forms of collective action is in part due to changes in the health sector that are not directly related to home birth activism. Far more important, however, in accounting for these shifts in home birth activism is the success of movement activists from the 1980s in changing the delivery of maternity services in New Zealand. In their annotated collection of key texts in social movement theory, Doug McAdam and David Snow argue that the effects of social movement activism have been undertheorised in the academic literature about social movements. They comment:

Presumably the ultimate justification for studying social movements lies in their potential capacity to bring about various kinds of social change. Those involved in social movements certainly assume the efficacy of social movements as vehicles for social change. Movement scholars do as well. It is surprising, then, that the impact of

social movements has been the subject of so little systematic scholarship (1997:461).

There are two main currents of thought among social movement theorists about how to analyse social movements. These are often referred to as the North American resource mobilisation school and the European new social movement theories.² These two approaches offer different ways of thinking about social movement success, both of which offer some interesting insights in relation to the contemporary home birth movement.

Social movement theorists associated with the resource mobilisation perspective define social movements as contentious or politically oriented collective action. Social movements, according to Sidney Tarrow, are "collective challenges by people with common purposes and solidarity *in sustained interaction with elites, opponents and authorities*" (1994:3-4, italics mine). Similarly, Tilly suggests that social movements can be identified "by looking for claim-making interactions between challengers and powerholders" (Tilly, 1998:457). He defines a social movement as:

... a sustained challenge to powerholders in the name of a population living under the jurisdiction of those powerholders by means of repeated public displays of that population's numbers, commitment, unity and worthiness. (1998:469).

This approach to social movements focuses on those with formal organisations that utilise publicly visible tactics to challenge government policies and public opinion. Darnovsky, Epstein and Flacks argue that this approach defines movement 'success' in terms of reforms to institutional structures and government policy (1995:xv). With respect to the home birth

² Currently these two schools are coming closer together. See for example the collected essays in the following books: Darnovsky, Epstein and Flacks (eds) (1995); Morris and Mueller (eds) (1992); Johnston and Klandermans, (eds) (1995); Laraña, Johnston and Gusfield (eds)(1994).

movement these gains include the greater visibility of home birth in policies and reports produced by statutory health agencies as well as changes in the legislation enabling midwives to practice without medical supervision and collecting the same fees as GPs for providing maternity care.

Tarrow's and Tilly's argument that movements are involved in sustained claims making interactions with elites suggests that reconfigurations in the relations between movement activists and elites can defuse a movement. Social movements, Tilly argues, "take place as conversations not as sole performances but as interactions among parties" (1998:467). Thus, when some movement demands have been acceded to by elites, it becomes difficult to maintain claims to represent an unjustly deprived population. Now that home birth activists are no longer taking on the whole maternity system the capacity to maintain "numbers, commitment, unity and worthiness" is undermined. I argue in chapter seven that the home birth movement has not only had to confront this effect of success, but also other shifts in the policy structure which closed down opportunities for collective challenges by community health groups.

Theorists from the 'new social movement' school are interested in social movements where participants engage in sustained *resistant* cultural projects without actively pursuing confrontations with authorities and elites (see for example; Darnovsky, Epstein and Flacks, 1995; Foucault, 1982; Touraine, 1985, Melucci, 1989). Social movements, Jean Cohen suggests, need to be seen as *complex* forms of social conflict. While contesting forms of domination, movement actors also collectively construct new social codes (1985:699). Italian social movement theorist, Alberto Melucci conceptualises new social movements as deliberate, yet fragile informal 'networks'. Within these networks, individuals collaborate to construct new meanings, alternate ways of negotiating interpersonal relationships and a sense of a 'collective identity' (1989:60, 222).

This approach to social movements includes networks where participants do not necessarily establish formal organisations or engage in actions directed at changing political and institutional structures, for example youth movements (Melucci, 1994) or the hippie counter-culture (Gusfield, 1994). According to Melucci, these 'networks' can nonetheless precipitate cultural conflicts by destabilising or calling into question particular dominant, taken for granted understandings and practices. They signal to a wider public the possibilities for alternative practices, identities and social relations (1989:29-30, 56, 206-207, see also Gusfield, 1994:62-66, 68-70; Mueller, 1994).

This approach, that conceptualises social movements as face-to-face networks in which people engage in constructing new social codes, is, I think, useful for analysing certain significant aspects of the home birth movement. In chapter five, I argue that the emerging home birth networks in the late 1970s and early 1980s were social spaces of cultural innovation, where birthing women/ families and home birth midwives collaborated to produce new sets of social practices and meanings for home birth. Out of this, the political claims and the collective identity of the movement were produced - both through resistance to hegemonic medical discourses of childbirth and through negotiating differences among the participants in these networks. In the final chapter I suggest that the contemporary home birth support groups and the emerging networks for Māori birthing women and Māori midwives may be new spaces for constructing alternate codes and practices with respect to birth and parenting.

For Ann Swidler, the problem many social movement theorists have with a cultural analysis is the lack of an incisive conceptualisation of culture. She argues against a Weberian view of culture as "powerful, internalized beliefs

and values held by individual actors" which social movements have to change (1995:25, and 30-31). Rather, she attends to the ways in which culture operates "in the contexts that surround individuals", shaping the ways in which they interpret and negotiate social interactions (1995:25, 32-39). Social movements may not change 'taken for granted' beliefs directly, as much as change the cultural codes through which people reflexively consider their actions and make assessments about how others might view these actions. In a similar vein, Joseph Gusfield proposes that social movements bring into contention "an area of life as at issue where it was previously accepted as the norm. Alternatives now exist where choice and contention were absent" (Gusfield, 1994:69). In chapter seven I examine the way in which this has occurred with respect to home birth activism. As more birthing women are questioning what they want for birthing and new birthing options are available that combine aspects of home and hospital birth, the sharp opposition between home and hospital births becomes undone.

In the following chapters, I suggest that home birth associations in the 1990s have become 'hybrids' of different organisational forms. While most home birth associations retain the structures to engage in the representational politics associated with social movement organisations, some have also become providers of services within the quasi-market of the health sector.³ Some offer support groups for women choosing to birth at home and voluntary services and information resources for members.

³ 'Quasi-markets' are limited markets in which service purchasing decisions are not made directly by consumers and there is a mix of private and public ownership (Cheyne, O'Brien and Belgrave, 1997:85-86). This is also sometimes referred to as 'internal markets' or 'government regulated competition' (Van de Ven and Schut, 1995)

Theorising the state?

An important focus for home birth associations in New Zealand since their inception in the late 1970s has been on making claims on the 'state'. Home birth associations have both resisted and sought changes to state regulations covering midwives and home births and supported the state provision of maternity services. They have pursued various strategies to gain more consumer involvement in maternity policy making and service provision. The past two decades have brought significant changes to government policies with respect to midwives' professional status and payment as well as two rounds of health sector 'restructuring'. My interest in this thesis is in examining the effects of changes in state policies and institutional arrangements in shaping the ways in which the home birth associations have constructed and reconstructed collective identities and political strategies. This requires some analysis of the state as a complex set of actors, relations and practices. This section will reflect on this social 'hydra' (Armstrong, 1992) to assess the changing context in which home birth associations have been operating in the 1990s.

In the late 1980s, a number of feminists were engaged in intense debates about feminist 'theories of the state' (see for example; Fraser, 1989; Franzway, Court and Connell, 1989; MacKinnon, 1989; Pateman, 1989; Sharp and Broomhill, 1988; Watson (ed), 1990; Yeatman, 1990). Some feminists, such as Catherine MacKinnon (1989) or Carole Pateman (1989), called for a feminist theory of *the* patriarchal state. Other feminist theorists questioned the usefulness of a concept of 'the state' (Allen, 1990). Rosemary Pringle and Sophie Watson argue that viewing the state as a "coherent, if contradictory unity" that inevitably favours patriarchal and/ or capitalist interests over those of women, the working class, and marginalised groups is too simplistic (1992:70; see also; Franzway, Court and Connell, 1989:37-

40, 45; Sharp and Broomhill, 1988:28-29). These kinds of accounts of the state are premised on a view of power as coercive, rather than also productive (Skocpol, 1992:37-38; see also; Foucault, 1980a:59-62, 122, 187-189; Miller and Rose, 1990). Home birth activists' interactions with the state in New Zealand illustrate that the state can act in the interests of those who are less powerful. Instead, we need to attend to the "tension of the state as both determinant and product of contestation, within and between social groups" (Armstrong, 1992:225).

Pringle and Watson suggest that instead of seeing the state as an 'entity' representing fixed sets of interests:

More usefully, we can conceptualize the state ... as a set of arenas; a by-product of political struggles whose coherence is as much established in discourse as in shifting and temporary connections. The current collection of practices which we refer to as 'the state' are a historical product, not structurally 'given' (1990:229).

A nation state, thus, can be regarded as a complex heterogenous network of arenas, each with specific though interconnected jurisdictions. These 'arenas' are "forums within which issues are debated, struggles ensue and decisions are made" (Fulcher, 1989:4-5). That is, these arenas can be viewed as targets for claims on behalf of various collectivities as well as sites of conflict between state actors with differing views and political agendas.

To understand home birth activism we need to attend to the various arenas into which activists sought to insert their claims. In chapters six to ten, I argue for attending to the complexities of the lines of conflicts and compromises between diverse state agencies, state actors and policy agendas. For example, to understand why home birth associations' and midwives' demands for midwifery 'autonomy' met with success, we need

to take account of the Minister of Health, Helen Clark's commitment to 'women's policy' and more consumer friendly health services, as well as neoliberal interests in increasing competition between health service providers. As I discuss in the following chapter, the state in New Zealand has a history of unsuccessful and some successful battles with powerfully organised doctors. We can see it as the instrument for enforcing the 'status quo', but also a significant lever for change.

Pringle and Watson argue for a poststructuralist rethinking of how we define the concept of 'interests'. They move away from a view of interests as determined by positions in a social structure, for example, that women or men or different classes each have unitary, pre-given interests (1990:229-230; 1992:66-69). Also, not only do differently positioned women have differing understandings of their interests, women will have different interests in the various social contexts they inhabit (see also; Du Plessis and Higgins, 1997:329-331; Mouffe, 1995:319). Instead, they argue, interests are constructed 'in relations' and through discourses.⁴ They write:

It is in the process of engagement with the arenas of the state that interests are constructed. Through creating frameworks of meanings, through the use of particular languages and discourses, certain possibilities for change emerge. Interests are produced by conscious and unwitting practices by the actors themselves in the processes of engagement. Feminists who engage with the state do so within a set of parameters that are discursively constituted and will formulate their interests accordingly. ... These will also be a result of 'past struggles' in which ... 'interests' ... have been constituted in the constraints and pressures on discursive availability (1992:69).

It is important to note that Pringle and Watson do not want to reduce the

⁴ Poststructuralist theorists make the same argument with respect to 'needs' (Fraser, 1989:chapter 8; Watson, 1995) and social 'subjects' (Scott, 1992; Weedon, 1987).

notion of 'interests' to individual 'preferences', as is done by advocates of neoliberal theories (see for example; Buchanan, 1986:51-53, 249-253; Upton, 1987:4-5) and some versions of resource mobilisation social movement theories (this criticism is made by Ferree, 1992:40-41; Mueller, 1994:234). Pringle and Watson and other poststructuralist feminists make the argument that interests are produced and discursively articulated in struggles for power and resources, which are the instituted effects of prior struggles.

In the next chapter, I utilise the notion of interests as 'contingent' and 'constructed' to examine birthing practices and policies in New Zealand over the last century. I examine the ways in which the 'interests' of diverse groups with a stake in maternity practices, such as birthing women, midwives, nurses, doctors and state actors are historically and contextually variable. I argue that rifts and divisions within each of these groups have led to complicated coalitions that cut across groups. For example, at different times groups of birthing women have formed alliances with groups of doctors against other doctors and midwives, while at other times some women have turned to particular groups of midwives. In these mobilisations, birthing women have demanded more control over birthing practices, but what counts as 'control' has ranged from the right to pain relief in labour to the right for a natural childbirth. This destabilises notions of predetermined interests and natural allies in the struggles for control in maternity services.

This historical account sets the scene for an analysis of the contestations through which home birth association activists constructed their particular interests in relation to other groups of actors over two decades of change. In the second half of this thesis I address the question of how the two major policy shifts at the beginning of the decade opened up new opportunities and presented new constraints for home birth activists. In what ways do the

various responses by home birth activists depend on, rework, and strain against the articulations of home birth interests constructed by activists in the 1980s?

I have argued for a view of the state as a 'hydra' (Armstrong, 1992) and interests as 'constructed' out of past actions and in relations of power. How are we to analyse this complexity and fragmentation? Instead of focusing on the network of institutions that make up a particular state, we can analyse the struggles over, and the programmatic effects of 'policies' (Miller and Rose, 1990; Skocpol, 1992; Watson, 1995; Yeatman, 1998).

Politics and Policies

In her book, *Protecting Soldiers and Mothers*, Theda Skocpol argues that: "What is needed is an approach much more sensitive to the political causes and the substantive contents of social policies" (1992:14). She suggests that examining the production and formulation of specific policies enables researchers to investigate the ways in which state organisations change over time, vary across policy arenas as well as differ from those of other nations (1992:42). Yeatman argues that the reason why it is important to look at policy processes is because modern states 'govern' through policies (see also; Miller and Rose, 1990:3-4). She contends that the:

The development of the modern 'interventionist state' extends the scope of the conventionalised phenomena which are understood to be subject to the artful intervention of policy. For a phenomenon to become subject to policy intervention means that it is brought into the domain of political action where it is reconstructed in relation to contesting narratives about who we are as citizens, what it is that we think we should do, and why. ... The constitutive role of the state is expressed not only in how the state names social phenomena but in how it proceeds to subject them to

policy (1998:18-19).

Yeatman depicts a relationship of interpenetration and interdependence between the state and the society under the state's jurisdiction. The ambiguity of the state's boundaries, Yeatman suggests, enhances the possibilities for the state's surveillance of our everyday lives, and at the same time increases the potential for the emergence of politicised groups (1990:44-45, 169). In this respect, childbirth in modern interventionist states is an excellent example of a 'social phenomenon' which has been intensively subjected to policy, and also the way in which policies result in ongoing power struggles among the interested groups.

State policy making is not simply an outcome, albeit an unpredictable one, of pluralist interests jostling for leverage. Some interests are already positioned in ways that secure greater input into policy formulation and implementation. Skocpol argues that political institutions provide access and leverage for some groups and alliances to be able to influence policy making, while marginalising or excluding others. This depends on the "fit" between "politicised social identities and group political orientations and capacities", on the one hand, and the "governmental institutions, political parties" and "the rules of the game", on the other (1992:54). To analyse policymaking processes, Skocpol examines the demands and counter demands, negotiations, reinterpretations and compromises through which policies are produced, implemented, monitored and re-contested. She advocates that such an analysis should be historically grounded, with attention to how the various groups interested in particular policies construct their identities and claims *in relation* to each other (1992:38).

The contents of policies and the newly authorised practices which emerge from policies, she contends, "can not be read back historically" to the initiatives and struggles through which they were produced (1992:38). That

is, policy may have very different outcomes to the ones intended by those who supported and formulated the policy. She argues that:

Women's groups, for example, may achieve legislative victories, but then be unable to control the implementation of social policies, so that they end up doing harm rather than good to many women. Or social policies may be supported by bureaucrats, or parties, or unions, or upper social classes, with the intention of "controlling" women, but then end up having beneficial primary or secondary effects on the situations of mothers or female workers. (1992:38)

Furthermore, just as policies change the actions of governing, they also reshape the political environment, enabling and delimiting the possibilities for the construction of new or remade politicised identities. As politics creates policies, Skopcol argues, policies create politics (1992:57-60). Policy analysis should, thus, not be confined to an analysis of policy statements, but also examine how the policies are interpreted and shaped though being implemented in practice - and the depoliticisations and repoliticisations that occur as a consequence. My account of the home birth association underscores the ways in which policies create new conditions in which old rivalries are played out. However, policy shifts problematise previous constructions of interests and can result in new political struggles.

In this thesis, I refer to these processes through which home birth activists seek to make claims in policy making processes as 'political opportunity structures'. McAdam and Snow define political opportunities as the shifting political and institutional processes for making claims and the ideological dispositions and alignments of different sets of political and institutional actors that facilitate or hinder the possibilities for social movement influence (1997:34-35; see also; Tarrow, 1994:82, 85-89). The term 'political opportunity structure' is also used to refer to the 'resources' that can be mobilised by the activists from any particular movement. These resources include existing communication networks with other movements and

interest groups that can be used to attract movement supporters, allies and points of access to political institutions. Potential resources also include organisational forms, strategies and protest tactics (Banaszak, 1996:30; Meyer and Whittier, 1997:488; Tarrow, 1994:82, 85-89). Political opportunity structures can be thought of as 'configurations' of discourses and social practices - such as rules, routines and insurgent tactics - which carry greater or lesser degrees of institutional legitimacy and temporal continuity.

Gamson and Meyer are critical of the way the concept of political opportunity structure is used to cover so much in resource mobilisation theory. They argue that:

The concept of political opportunity structure is in trouble, in danger of becoming a sponge that soaks up virtually every aspect of the social movement environment - political institutions and culture, crises of various sorts, political alliances, and policy shifts. ... It threatens to become an all encompassing fudge factor for all the conditions and circumstances that form the context for collective action. Used to explain so much, it may explain nothing at all. (1996:275)

Following Gamson's and Meyer's critique, in this thesis I will utilise the concept of political opportunity structure to examine and compare different incidents of political mobilisation with respect to policy making processes by home birth activists in New Zealand. My analysis of the home birth activists' engagement with the state examines the ways in which the movement identities and strategies *and* the political opportunity structures have been produced, reproduced and altered through episodes of conflict between movement activists, their allies and opponents and state actors. Tilly emphasises the point that:

... political opportunity structure significantly constrains the histories of individual social movements, but that movement

struggles and outcomes also transform political opportunity structures (1998:445-446).

However, a critical issue for home birth activists is that the political opportunity structure for their particular claims has been 'transformed' through the intervention of other interested groups, particularly the programme of health restructuring which began in 1991.

Vicki Randall offers a different critique of this concept. She argues that it 'reifies' the public/ private dualism that feminists and other social movements have sought to challenge (1998:194). While this is an important point, home birth activists in New Zealand have themselves separated 'private, peaceful birthing at home' from responding to, and fighting for policy changes. As I discuss in chapter five, this dualism emerged early in the home birth movement and has been a source of tension within the home birth associations. In later chapters I investigate the crossovers between the two sides of this dualism. These include the cooption and institutionalisation of practices of home birth that were developed in the privacy of the domestic sphere in the late 1970s and 1980s within home birth movement networks, and the way in which efforts to keep control of these practices within home birth networks pushes activists to attempt to intervene in policy arenas in particular ways.

Anna Yeatman suggests that analyses of policy processes need to attend to the various interconnected and intersecting stages of the policy process. These include: setting the policy agenda, policy development, policy formulation, policy implementation, policy delivery, policy evaluation and policy monitoring. Each of these points offer possibilities for contestation and intervention on the part of various groups with an interest in the policy (1998:11). She suggests, however, that different kinds of interest groups have greater access to some, rather than to other stages of this process.

This offers an interesting way of exploring the political claims put forward by home birth activists. To which stages of the policy process are their claims directed? How do these claims attempt to contest which groups have privileged access to these different policy arenas?

I argue that home birth activists have had the least access to policy development, formulation, implementation, delivery, and monitoring, and have had to rely on submissions and lobbying politicians. Home birth activists have been successful in influencing policies through policy evaluation - the evaluation of the "responsiveness" of policies "to citizen need" (Yeatman, 1998:11). These evaluations in turn have raised new policy agendas. Chapter eight examines how home birth activists utilise their access to the New Zealand College of Midwives to attempt to increase the opportunities for participation in the other policy making arenas. In chapters nine and ten, I examine how some home birth activists are seeking greater input into policy processes through configuring the delivery side of services. These chapters examine the question of how this may impact on the political opportunities for home birth activists to participate in the other stages of the policy process.

Collective action frames

In this thesis, I apply the notion of 'collective action frames' to describe how home birth activists utilise language as a resource. Arguably the term 'collective action frames' has similar meanings to other terms used for cultural analysis by social movement theorists and social theorists more generally, such as; 'discourses', 'interpretative repertoires', 'rhetorics' and so on (see for example the collections edited by Darnovsky, Epstein and Flacks 1995; Laraña, Johnston and Gusfield, 1994; Johnston and

Klandermans, 1995). 'Collective action frames', however, highlights the specificity of the discursive packages produced by social movements as opposed to other forms of collectivities. Movement collective action frames are produced by social movements through engagement in challenging collective action or power struggles. They, thus, refer to a specific form of communicative action - the way movement activists 'think' and represent themselves 'as social movements' and articulate their critiques and demands in public and political arenas.

Drawing on Goffman's ideas about 'framing', Snow, Benford and various colleagues, define 'collective action frames' as movement specific understandings which:

... focus attention on a particular situation considered problematic, make attributions regarding who or what is to blame, and articulate an alternative set of arrangements including what the movement actors need to do in order to effect the desired change. (Hunt, Snow and Benford, 1994:190)

Collective action frames describe how movement participants cognitively and discursively map the field towards which their action is oriented as well as their place within it (Johnston and Klandermans, 1995:8). In doing this, movement participants construct politicised definitions of themselves - 'collective identities' - which guide their decisions, actions and their relationships to each other. These frames are socially constructed through ongoing negotiations and debates among movement participants and through conflicts between movements and the 'adversaries' they seek to challenge (see also; Gamson, 1992b:67-68, 1995:89-102; Snow and Benford, 1992; Snow, Rochford, Worden and Benford, 1997 (1986); Tarrow, 1992:187-198).

Gamson argues that collective action frames include three interconnected

components which he terms as 'injustice', 'agency' and 'identity' claims (1992a:7-8). These can be viewed as the ingredients of the framing packages that movements need to produce to be recognised by others outside as constituting a social movement - a particular kind of challenge to social and institutional conventions. Firstly, Gamson contends, that the capacity of collective action frames to inspire movement participation is enhanced when problematic social arrangements can be reframed from a 'misfortune' into an 'injustice'. Injustice frames identify the movement's 'antagonists' and represent them as "motivated human actors who carry some of the onus for bringing about harm and suffering" (1992a:7-8). Collective action frames are, therefore, 'adversarial' or rhetorical arguments that are constructed to contest taken-for-granted, commonsense assumptions or the framings put forward by opponents (see also; Blain, 1994:819; McAdam and Snow, 1997:xxiii; Mueller, 1994:159; Snow, Rochford, Worden and Benford, 1997 (1986):236).

In the 1980s, home birth activists constructed a collective action frame which incorporated all these 'ingredients'. Their adversaries were those obstetricians, doctors, nurses and state actors who not only opposed home birth, but also supported medical control of childbirth. Birthing women were constructed as 'victims' of the medicalisation of childbirth practices. The agency offered by the home birth associations' collective action frame was to 'exit' hospitalised childbirth by choosing to birth at home. The identity of women who birthed at home was 'women who wanted to be in control of their birthing experiences', who were prepared to take responsibility for their decisions and had faith in women's ability to give birth without medical intervention. Activists publicly advocated for women's right to choose where they birthed. This is discussed in more detail in chapters five and six.

Snow and his colleagues argue that movement participants do not create

collective action frames from scratch. Instead, they draw on and rework existing frames which are already recognisable to other potential participants and supporters. Snow, et al refer to this as 'framing alignment processes'. (Snow, Rochford, Worden and Benford, 1997 (1986)). McAdam suggests that these frame alignments by participants of a social movement "can be thought of as acts of cultural appropriation" and re-presentation (1994:37-38). Swidler suggests that:

... frame alignment ... is not just a matter of individuals getting their frames in sync. Rather, individuals develop common scripts in response to the features of the institutions they confront. (Swidler, 1995:38)

These link the interactive meaning construction which occurs within a social movement network with wider sets of cultural understandings (Johnston and Klandermans, 1995:9; Taylor and Whittier, 1995:168).

The focus of theorists who use a collective action frame perspective has been more on the external orientation of movements' discursive challenges. Their interest has been how identities and frames are strategically deployed in public spheres by movement activists to mobilise political and popular support for their movement's goals (Snow, Rochford, Worden and Benford, 1997 (1986)).⁵ Johnston and Klandermans suggest that a collective action frame analysis is a useful tool for examining the documents, public statements and media reports put forward by movement organisations. They argue that frame analysis:

⁵ In a more recent work, Hunt, Benford and Snow attempt to collapse the gap between the internally and externally oriented meaning negotiations of social movements through a "micro-frame" analysis of the 'talk' of individual social movement participants. To illustrate this approach they use examples of the internal debates among movement participants over strategic assessments of possible public responses to different constructions of collective identity (1994:194-203).

... is particularly relevant in today's movement environment, in which groups and organisations strategically consider the effects of their actions on the media and on the public at large. Frame analysis at this level unites the systemic perspective of dominant cultural patterns with a performative analysis ... of groups, organisations and institutions. (1995:8)

I will use the term 'collective action frame' to refer to the public voice of the home birth associations, that is, the statements made by home birth activists and representatives in the media, including the home birth 'media' of newsletters, and in public and policy forums.

A point that I think needs to be emphasised is that these collective action frames are continuously reproduced and reconstructed through engagement in, and shared reflection on, political debates. Attention needs to be paid to the problems posed when key frames lose their salience or explanatory and persuasive capacity as a result of policy changes and rearrangements in the relations of power between competing groups in the political field. To paraphrase Tilly, collective action frames are constructed through "conversations" not "sole performances" (Tilly, 1998:467). This, I argue has been a problem for contemporary home birth activists. The very effective collective action frame developed in the 1980s could no longer explain the complicated deployments of power in the 1990s.

Conclusion

The arguments put forward by theorists interested in state processes suggest that account needs to be taken of the historical constructions of interests and lines of contestation and coalitions between multiple and diverse groups within a particular field. Thus, interests are constructed through conflicts and alliances, as well as the 'rules of game' of state policy

processes. Not all those who might have an interest in particular policies have equal access to determining what the policies should be. One way that marginalised groups can gain access to policy processes is through collective action. Thereby they also demand changes to the policy making processes and ensure more participation for movement representatives. This, however, is an uncertain enterprise.

New social movement theory suggests that movements do not always seek power in the polity, or if they do, this may be less significant than the alternative social practices and the investment in a collective identity pursued within movement networks (Darnovsky, Epstein and Flacks, 1995:xiv). In these networks participants make diagnoses of the social problem they are seeking to remedy and suggest possibilities for change. In the 1970s and 1980s women/ families and domiciliary midwives active in home birth associations were engaged in such cultural innovation. However, it was the activism directed toward policy changes that enabled these new practices to extend beyond home birth networks. These changes have, however produced unanticipated and unintended consequences that present new challenges for contemporary home birth movement activists.

3

Constructing reflexivity: an insider/ outsider analysis of home birth associations

Introduction

Liz Stanley and Sue Wise make the argument that knowledge is always located and specific. That is:

... all knowledge necessarily results from the conditions of its production, is contextually located, and irrevocably bears the marks of its origins in the minds and intellectual practices of those lay and professional theorists and researchers who give voice to it (1990:39).

In light of this, they advocate that feminist researchers reflexively analyse the research and writing processes which lead to the production of knowledge claims (1990:28). In this chapter, I describe the various stages of

this research project and some of the dilemmas and decisions that 'produced' this thesis. In particular, I discuss the challenges and possibilities that emerged out of my dual positioning as both a long term activist in the home birth movement and a feminist sociologist who critically analyses this movement. The third section outlines the practical concerns with respect to defining research questions, ethical considerations and selecting research participants. It includes reflection on how I approached home birth associations to invite their participation and why I contacted particular home birth associations. I then go on to reflect on the group interviews and discuss how my research questions shifted as I became clearer about my research agendas.

Getting started: biography and topic choice

When I began this thesis, I envisaged that it would take the form of a discourse analysis¹ of the debates surrounding the formulation and implementation of the 1991 health sector restructuring in New Zealand.² My deconstruction of the diverse positions on the health reforms was to be framed through Anna Yeatman's (1990) conceptual frame of the 'politics of discourse' and Nancy Fraser's (1989) 'politics of needs interpretation', with attention to the gendered subtexts of these discourses and possible effects

¹ I wanted to use the approach to discourse analysis advocated by Chris Weedon which takes texts as sites of bids for power/ resistance in complex and contradictory relations to other texts (1987:107-114, 163-167).

² The initial health sector restructuring policy included separating funders from providers of health services, instituting income tested part-charges for most hospital services and abolishing all elected members of state health agencies. Also, the health reform policy raised the possibility for non-governmental organisations to establish health care plans in competition to government funders of health services (Upton, 1991). This has never been instituted.

of these policies on different groups of women.³ I was particularly interested in the impact of these policies on opportunities for feminist health activism. My research material included governmental policy documents from the various bodies involved in implementing different aspects of the health sector restructuring, submissions by voluntary organisations and interested individuals, speeches by Members of Parliament, media accounts, and the international debate between advocates and opponents of the new economic approaches to health. Although the focus of the research shifted to the home birth associations in New Zealand and to the new ways of organising and funding birthing services, these initial interests have influenced my topic definition and the kinds of questions that this thesis addresses.

After working on the health reform documents for a couple of years, the shifts in the process of implementing change in the health sector became so rapid that aspects of my analysis had to be continually revised. However, there was, for me, a more critical problem. Although my motivation for the thesis topic was to provide knowledge which would be useful for feminist health activists, the focus on macro-agendas reduced the practical applicability of my analysis. I was also inadvertently reproducing in my own work the relative invisibility of the voices of feminist and other health activists in the restructuring debates. Yet, the marginalisation of various health activists' concerns was a key criticism I made with respect to the policy debates I was examining. Consequently, I decided to change the

³ Yeatman defines politics of discourse as follows: "Political activity itself [has become] preeminently a politics of contest over meaning: it comprises the disputes, debates and struggles about how the identities of participants should be named and thereby constituted, how their needs should be named and thereby constituted, how their relationships should be named and thereby constituted. ... Politics comes to be appreciated as a politics of discourse when social complexity reaches the point, as it has now, where it becomes impossible to maintain old ideals of reconciling opposing interests within a single standard of justice" (1990:155-156). Fraser uses the term the 'politics of needs interpretation' to refer to a similar process.

perspective of my analysis of health policies by researching community health groups that were actively engaged in trying to craft new positions and new politics for their advocacy work in a changing context.

When I began work on the thesis, I was also involved with the Christchurch Home Birth Association committee, the Christchurch Maternity Action Alliance, and I was a consumer member of the national committee of the New Zealand College of Midwives,⁴ representing the Maternity Action Alliance. While my discourse analysis of the health reforms was stalling, I saw around me that a variety of responses to the reforms were emerging from different home birth associations around New Zealand. At meetings of activists from different associations and in College of Midwives' forums, there were lively debates about the health sector restructuring. Although most women involved in these networks were critical of what came to be referred to as the 'health reforms', questions of how to make sense of and challenge what was going on and how to fruitfully engage in collective action with respect to maternity services policy debates provoked a range of responses.

Some home birth groups were exploring the new opportunities to tender for contracts with statutory authorities to deliver home birth services, while others eschewed contracting in an attempt to maintain a political 'edge'. Still other home birth groups concentrated on services to members and semi-formal support groups. Furthermore, long term home birth association activists who had been involved in policy activism through two successive rounds of health sector restructuring had devised a repertoire of strategies to pursue their political aims. These differences over time and in

⁴ The New Zealand College of Midwives national committee is made up of the regional chairpeople of each of the ten regions of the College, three representatives from Nga Maia O Aotearoa Me Te Waipounamu, Māori midwives collective and three consumer representatives.

the varied approaches taken by different local associations in response to the 1991 health reforms offered exciting opportunities for investigating some of the complexities of the restructuring process. The successful negotiation of a contract to provide a complete home birth service by members of the Manawatu Home Birth Association at the end of 1995 prompted me to redefine the direction of the thesis.

In turning my attention to home birth activism, this thesis became a case study of a social movement. It is, however, different from the case study I might have done if I had begun with an investigation of the home birth associations, rather than the discursive and organisational context in which they and other health focussed community groups were operating in the 1990s. My questions in this thesis are about how activists from various home birth associations think about, and act collectively with respect to negotiating complex sets of relations with state agencies, with midwives working in their area, the New Zealand College of Midwives, other community groups, other home birth associations and women and families who choose to birth at home. I am interested in the lines of change and continuity in the politics of home birth activism.

The notion of undertaking a policy analysis from the perspective of those who are outside the 'ruling apparatus' or who struggle for the inclusion of their voices in policy making has some academic legitimacy. Standpoint feminists in the late 1980s insisted that knowledge production should start with the experiences of those who are oppressed in relations of power (see for example; Harding, 1987, 1990; Smith, 1987; Stanley and Wise, 1990). Michel Foucault, similarly, suggested that "...in order to understand what power relations are about, perhaps we should investigate the forms of resistance and attempts made to dissociate these relations." (1982:211). Italian social movement theorist, Alberto Melucci argues that social movements, or collective struggles, offer a privileged point of view from

which to inquire into power relations, because movements act as 'revealers', exposing the hidden, excluded and arbitrary effects of power (1989:76-77; see also Buraway, 1991:285-287). Reflecting back, as this thesis reaches completion, I would not claim that it produces a definitive understanding of the power relations in the restructured health sector. Instead, I offer a partial and situated account about the possibilities and constraints for community health activism with respect to maternity services under policy frameworks which are strongly influenced by neoliberal agendas.

Although my original intention was to analyse the 'health reforms', in shifting my attention to the home birth associations, I needed to take account of local historical contexts and contingencies which shaped the responses of home birth activists to the new health system. How did the investments in certain discourses and strategies by home birth activists in the 1980s open and limit possibilities for home birth collective action in the 1990s? What opportunities do other key groups of actors in maternity services - GPs, obstetricians, state administrators, midwives - seek to exploit in the reconfiguration of the health sector to further their bids for power and control over maternity services? The changes to the legislation enabling midwives to practice without medical supervision in 1990, which came out of the political demands of home birth activists, raised another set of questions about the challenges of 'success' for movement organisations. Taking account of these complexities pushed me to pay attention to the local and historical background of the home birth associations, making this more a 'case study' than I had first imagined. At the same time, if this thesis is to lay claim to being more than what Linda Nicholson and Nancy Fraser disparagingly call a "local mininarrative" (Fraser and Nicholson, 1990:25),⁵

⁵ The works by Dorothy Broom (1991) *Damned if we do, Contradictions in women's health care*, and Kristin Luker (1984) *Abortion and the Politics of Motherhood*, provided me with useful insights for 'doing' a case study which

and enable readers and researchers to make connections between the story of home birth associations in New Zealand and other forms of community activism, these local and historical specificities need to be critically examined.

The challenge of insider research

A key issue for me in undertaking this research on the home birth associations in New Zealand is my dual positioning as both an active participant and as a researcher of this movement. The difference between these two 'selves' is by no means clear cut. I was, for instance, introduced to sociological and academic feminist theories before I became involved in the Christchurch Home Birth Association in 1986, and thus these theories contributed to my sense making of home birth activism. I returned to complete my undergraduate degree in 1989 and then proceeded to graduate studies. I used the new postmodern feminist and sociological theories I encountered to reflect critically on my practices as an activist, as well as to interrogate these theories using the knowledge I acquired through home birth activism.⁶ Nonetheless, the differences between being positioned as an activist and as a researcher were highlighted for me at various times while I was working on this thesis. For example, on several occasions I found myself in positions where, as a home birth association representative, I would present rhetorical political arguments with respect to an issue, while, at the same time, I was writing chapters that incorporated more critical and complex arguments about this issue. And yet, the understandings I gained through the thesis writing have influenced the positions I might adopt in debates with other activists and helped me

locates a particular movement within its wider social and political contexts.

⁶ These included theorists such as; Jane Flax (1987), Michel Foucault (1980a; 1980b), Elizabeth Grosz (1988), Joan Scott (1988) and Chris Weedon (1987).

construct clearer political arguments.

Conducting research on a set of organisations in which I was (and still am) actively involved posed some interesting challenges. Sasha Roseneil discusses some of the challenging methodological issues that emerged for her doing 'insider' research on a social movement - the Women's Peace Camps at Greenham Common (1993). These include the problems of finding a critical distance from the subject matter, constructing an ethical research design and facing the potential of criticism from others involved in the movement. These are concerns that I have also had to work through in my research and writing process.

Roseneil notes that insider research breaks the rules of positivist epistemology which demands that the observer should adopt a detached and objective stance toward the researched (1993:179-181; 192). While Roseneil rejects a positivist epistemology, she nonetheless encountered the problem of "being too close to the subject-matter ... to be able to see the sociological significance of that which appears completely normal" (1993:192). Post-positivist social theorist, Michael Buraway, cautions that participant observers in social research must retain their 'observer status' to be able to understand both the particular social arena being studied and the wider relations of power, or 'systems world', in which these arenas are located (1991:284). Dorothy Smith holds a similar position, arguing that while feminist research should begin inquiry from women's experience "we can not rely upon them for an understanding of the relations that shape and determine" these experiences (1987:110).

Smith (1987:107-109)⁷ and Buraway (1991:26) recognise that women/ lay actors also construct social theories and that these can provide grounds for

⁷ See also Patricia Clough (1993) and Stanley and Wise (1990:34-36) for a discussion of Smith's argument.

critiquing and reconstructing academic social theory. For example, Smith explains her 'sociology for women' in terms of: "I've wanted to rewrite sociological conventions so that sociological discourse is ... changed by having to rediscover the society through the experience of those who live it" (1993:190). A stronger version of this argument is offered by Buraway, who asserts that:

Participant observers are particularly aware of lay theories, or commonsense knowledge, and this can provide a point of departure for reconstruction [of social theories]. Moreover, there is a circular movement in which social science built on reconstruction of common sense feeds back and transforms that common sense. ... The new theory of today becomes the conventional wisdom of tomorrow (Buraway, 1991:26).

Buraway makes an added argument that lay theories may already incorporate sociological concepts. This point is particularly relevant for understanding home birth movement activists whose politics are the instantiated practices of liberal and radical feminist and academic liberal social theory discourses.⁸ Furthermore, both Smith and Buraway intend their work to feed back into everyday worlds to help people understand the "social relations that organise and shape our lives" (Smith, 1993:190). While in different ways, Smith and Buraway argue that social theory has political effects, and both are committed to enabling people to exercise more control, they reinvest in claims of sociology to expertise.

The troubling issue for me with this dichotomy between 'social researcher' and 'researched' is that it can lead to social researchers claiming to hold a greater understanding of people's lives than they do - a claim I do not want (or think I can) make. It is, I think particularly problematic when researching a social movement such as the home birth movement, in which activists who engage in challenging collective action collectively theorise the social

⁸ This is discussed in detail in chapter six.

relations in which they are located (Melucci, 1994:111-114; 1995:62). Thus, we have a tension between, on the one hand, being too close to see the sociological significance, while on the other, achieving a distance which constitutes the researcher as an "expert over and above other women's experiences" (Stanley and Wise, 1990:24).

Sandra Harding (1987:8-10), Stanley and Wise (1990:24, 43) and Roseneil (1993:180-181) argue that one way around this tension is to locate the researcher and the researched on the same 'critical plane', such that the (feminist) researcher practices a critical reflexivity about how she produces knowledge claims and makes this explicit in her writing (see also; Jones, 1992; Aldridge, 1993). Although this chapter is based on this kind of explication, I do not, in the rest of the thesis, continue to articulate the 'subjective' elements which shape my analysis. However, the image of a 'critical plane' has been useful for me in this project. It offers a way of situating the knowledge I have gained through participation in a particular social movement and the knowledge that comes from sociology and academic feminism. Each can be viewed as arenas for producing knowledges in response to different political contexts. Locating these knowledges on the same critical plane has operated as a form of 'mental hygiene' (Haraway, 1988:578), enabling me to take myself seriously in both contexts while at the same time avoiding any claim to superior expertise as an activist or an academic researcher.

This approach is similar to that advocated by Melucci in his more recent work. He suggests that "scientific knowledge" production and social movement collective action can both be viewed as "particular forms of social action" (1995:62). He continues that:

Acknowledging both in ourselves as scientists and in the collective actors the limited rationality that characterizes social action, researchers can no longer apply the criteria of

truth or morality defined a priori outside of the relationship [between researcher and collective actors]. Researchers must also participate in the uncertainty, testing the limits of their instruments and of their ethical values (1995:62).

My commitment to locating academic and activist knowledges on the same critical plane shaped the research design and writing processes for this project. In research situations I sought to facilitate articulations of the knowledge held by home birth activists. Their words are quoted at some length in the following chapters. Thus the text becomes a kind of a dialogue between different sets of knowledge.

Thinking about being simultaneously a participant and a researcher as an engagement in a dialogue between two sets of 'limited rationalities' does not necessarily solve all the practical problems associated with 'being too close to the subject-matter to see its sociological significance'. Margot Ely argues that

... being too familiar is less a function of our actual involvement in the setting than it is of the research stance we are able to adopt within it. We are too familiar when we 'know' the answers ahead of time, or when we feel too close, too distressed, too disinterested, or too biased to study the situation, *or when we realize that the people in it do not accept us in our researcher roles*. We are too familiar when we cannot make the familiar unfamiliar (Ely,1991:16, italics mine).

I, too, was concerned that I might be caught in not being able to 'make the familiar unfamiliar'. I was also concerned about not being accepted in a dual researcher/ participant role within home birth networks when I decided to research the home birth associations and I had to think of ways to address this in my research design. Roseneil suggests that she was able to achieve the necessary critical distance in her work because she began her research four years after she had left Greenham Common (1993:192). To

work through this dilemma, I decided to focus on interviews with activists from a range of home birth associations, rather than utilise an explicit participant observation method to ground the analysis in this thesis. Thus, although I was both a participant and observer, my participant observations in this work are tested against what other home birth activists actually say. This also helped me to achieve a critical distance 'to see the sociological significance' in that which I took for granted. The interviews generated rich and interesting transcripts that became a world of texts I could analyse.

Group interviews with members of home birth associations from different parts of New Zealand enabled me to achieve some degree of bracketing between the contexts where I was a researcher and those where I was an active participant. This bracketing was not always easy to maintain and slippages between these two roles did occur. For instance, several times activists who participated in the interviews told me things outside of the interview that they wanted me to know as a researcher and did not repeat these in the interview setting. Or conversely, because of the talk beforehand, on a couple of occasions, during the interview I thought participants said more about an issue than they actually had, and failed to ask for elaboration. In the interview settings, however, I felt that the participants constituted me as a researcher, although a particular kind of researcher - as one who was 'knowledgeable' about some of the history and complexities of home birth politics.

I had some anxieties before I began interviewing that participants might feel defensive about putting forward arguments that were different from those I had adopted in home birth association forums. The Christchurch Home Birth Association committee from 1992-1994, of which I was a member, were critical of tendering for contracts with regional health authorities. We disputed the claims of health administrators and the Minister of Health that

contracting out maternity services through a bulk-funding process would lead to more consumer choice (Upton, 1991:123). I represented the Christchurch Home Birth Association's position at the Aotearoa/ New Zealand Home Birth Associations conferences in Gore in 1992 and in Rotorua in 1994.

Some of the women who participated in group interviews were present at these conference discussions. I raised this beforehand with the home birth activists who acted as contact people from the Tauranga, Manawatu and Auckland Home Birth Associations (the three associations included in this research that were most proactive about contracting) to check whether they considered this might be problematic - which they did not. It seemed to me that the interview group participants assumed that in my role as a researcher, I would take an impartial position. As a result of the discussion at the 1994 conference and through the first interview with members of the Tauranga Home Birth Association I revised my personal position on contracting and saw more complex political possibilities for home birth groups engaging in this relationship with state health funding authorities.

My insider knowledge provides invaluable resources for this project. Being a participant in the network of organisations I was studying informed the decisions I made about which associations to interview and helped me to formulate appropriate interview questions. It kept me in touch with changes in organisations and policies that would have been difficult to follow if I had not been a member of the national committee of the New Zealand College of Midwives and had the opportunity to attend home birth conferences as a representative from the Christchurch Home Birth Association. I had also met the key contact people in each area where I conducted an interview before I approached them. And, perhaps most importantly, I could draw on my knowledge of the political history of the home birth movement to analyse the ways in which this movement has changed.

Interviewing groups

For this thesis, I conducted interviews with self-constituted groups from eight home birth association committees or 'core groups'. I also interviewed four women individually, in situations where it was impractical to organise a group interview.⁹ A total of 49 women and one man participated in formal interviews for this research.

At the outset of taking up a case study approach, I decided to conduct group interviews with core group/ committee members drawn from a number of Home Birth Associations.¹⁰ The choice of group interviews was informed by my understanding of research ethics with respect to the analysis of organisations with a strong commitment to collective responsibility. One of the tacit rules for many home birth groups, as it is for many feminist and other political self-advocacy groups is that no one person speaks for the group without ensuring that what they say reflects the understandings of others.

Group interviews are often currently referred to as 'focus groups' in social research (see for example; Kitzinger, 1994; Morgan (ed) 1993; Morrison, 1998; Wilkinson, 1998). There is an interesting debate among theorists of focus groups about who has control in focus groups. David Morrison argues that the "moderator is much more in control of the interview situation in focus group research than the interviewer is in the single in-depth interview", because the moderator can control the conversation by shifting it to other participants (1998:210). Sue Wilkinson, by contrast, argues that in focus groups "the researcher's power and influence is reduced, because she has much less power and influence over a group

⁹ These are discussed later in this chapter.

¹⁰ As I will explain later, I also conducted four individual interviews.

than over an individual" (1998:114; see also Morgan and Krueger, 1993:15-16). Perhaps this depends more on the way a moderator/ researcher interacts with the group participants than on the method itself. My intention in utilising group interviews was to maximise the control which could be exercised by the participants over the information collected about them for this research.

There are a number of ways that the focus group interviews I conducted differ from what is often understood by that term (see for example; Morrison, 1998; Morgan and Krueger, 1993). In this case the groups were self-constituted, the participants in each group were all already known to each other and many of the questions asked were specific to the particular group being interviewed. I was seeking to generate knowledge about these particular organisations, rather than a broader population which the groups might represent. James Frey and Andrea Fontana argue that distinctions should be drawn between different types of focus groups. In their terms, the interviews used for this research would be described as 'formal field group interviews'. These are semistructured interviews with groups of people who are members of the collectivity or field that is of interest to the researcher (1993:31-33).

There are good methodological reasons for undertaking group interviews with participants of social movement organisations. The focus of my research is on *collective* activity - the processes through which home birth association members constitute themselves as a group, develop shared understandings of the opportunities and constraints for action in maternity politics and the health sector restructuring processes, and represent themselves to others. Melucci advocates the use of group interviews for studying social movement networks when a researcher seeks to understand the ways in which "discourses are constructed through actual interactions" (1995:60). Surprisingly, group interviews are rarely used in social

movement research.

In the group interviews, questions that worked well produced patterns of discussion where participants were eager to talk, finish off each others sentences, enter the conversation repeating the words of the last speaker, and 'negotiate' differing points of view. In these processes of 'talk' participants produce, or reaffirm a shared collective interpretation of an issue. Wilkinson argues that if the reason for choosing group interviews is that the researcher is interested in the co-construction of meaning, this needs to be made visible in the way extracts are quoted and analysed (1998:112-114, 121-122; see also; Morrison, 1998:250). In the interview transcript material included in this thesis, I have used extended excerpts to indicate the ways in which the comments have emerged out of particular discussion contexts.

There was never any difficulty initiating discussion in the interviews. More often the problem was that it was difficult for me to find gaps to ask for elaboration or clarification of interesting comments. All but one of the group interviews included children and babies. After the interview with members of the Eastbourne Home Birth Support Group, I wrote in my field diary:

Doing interviews the home birth way! Lots of babies and toddlers, breastfeeding. The little ones want to participate too, especially with doing the sound. They just 'know' what is the most important thing in the room, the thing everyone's attention is on when they speak - the tape recorder. So here I was again, intensely trying to concentrate on what the women were saying, and constantly making sure the tape recorder was still alright. ... And their mothers move around all the time too - to rescue children, help them with food and drink, mediate their 'play', check on explorers who have found the door and the stairs beyond, stand up to rock a baby to sleep, half their attention on the interview and half on their children. They move in and out of the interview space, and yet the momentum keeps flowing with a specific kind of

mothers-of-small-children efficiency. Constantly on the verge of chaos, it works - it is very special, and very unlike the ideal standard format of a group interview (7 May, 1998).

Posing questions

I devised a list of questions related to the kinds of issues I wanted to explore in the thesis. The question schedules for each group interview are included in Appendix II. Some questions were specific to a particular group, while others were more generally asked of most groups. For instance, interview group participants from home birth associations that were involved in negotiating contracts, or that held contracts with a regional health authority were asked how they had decided to pursue this option, what negotiations had occurred and what the effects of holding a contract had been for their association. Groups that included members who had been involved for a number of years were asked about their assessments of the changes and continuities for home birth activism generally, and their association more particularly, over this time. Other questions explored issues around their relationships with local midwives, the New Zealand College of Midwives and state agencies.

In most of the interviews, I asked questions about what their association was doing with respect to Treaty issues and Māori members. These questions were uniformly unsuccessful in eliciting discussion. Participants in several groups observed that the home birth associations tended to be mainly Pākehā organisations and that Māori women interested in home birth sought out Māori midwives. In one interview, a long term activist commented that she did not want to talk about it "because it was too painful" - so I did not pursue the question. In two interviews, plans were discussed for committee members to attend Treaty workshops. No women

identified as Māori in the context of the interviews, although I tried to frame questions in such a way that it would be clear that I was not assuming that the participants were all Pākehā. I had hoped to be able to include more about the issues surrounding Māori and Pākehā relations within home birth networks in this thesis. Currently, there is a resurgence of home births among Māori,¹¹ but I was not able to locate and negotiate an interview with a Māori home birth group.

I prepared for each interview by reading the newsletters and annual reports for the Aotearoa/ New Zealand Home Birth Associations conferences from the particular association. The mechanism for networking between home birth associations is through sending out newsletters to all the other home birth associations, so I had easy access to information produced by other associations. After the first interview, which I conducted with the Tauranga Home Birth Association, I sent several copies of the question sheets to the contact person beforehand.¹² The question schedules were not strictly adhered to because my intention was that the questions should stimulate rather than constrain conversation. I usually restated the questions rather than reading them off the sheet, and changed the order according to points that were raised in the discussions.

¹¹ The only statistics collected comparing Māori and non-Māori home birth rates come from the Midland area, the middle third of the North Island. These note that the Māori home birth rate has climbed from .8% in 1991 to 4.4% in 1997. The non-Māori home birth rates have also increased, but not by the same magnitude - from 2.6% in 1991 to 5.3% in 1997. The steepest increase for Māori home births occurred in the final year of the data collection when the rate rose from 3.0% for 1996 to 4.4% for 1997 (Midland Office of the Health Funding Authority, 1998:57).

¹² I did not do this for the Dunedin Home Birth Association group interview. See Appendix I.

Selecting associations and setting up interviews

Once I had decided to focus on the home birth associations, I had to make decisions about which associations to select. I wanted to attend to diversity among home birth associations. Therefore I was interested in talking to groups from associations who had successfully negotiated contracts, groups that had been unsuccessful and groups whose committee members were critical of contracting. I also wanted to conduct an interview with an association based in a rural area. Another consideration in the selection of groups was differences in the significance attached to sustaining ties between a particular home birth association and the local branch of the New Zealand College of Midwives. As my work progressed, I became aware that in my selection of home birth groups, I had left out an important dimension of home birth collective action - the support groups. I decided to interview a group oriented to support for members, rather than politics and contracting.

As I discuss in the profiles of each interview in Appendix I, the final selection of the groups interviewed did not neatly fit these criteria, because in the time between deciding on the groups to approach and actually arranging the group interviews, the positions of some of the groups changed. Two associations I selected because the membership included women from small rural communities both stopped holding meetings and went into recession during the time that I was organising the interviews. This is not untypical of associations in areas with a low population density - where there are few home births and women often have to travel long distances to be able to meet each other. I interviewed groups of members from the Auckland, Tauranga, Manawatu, Wellington, Christchurch, Dunedin and Southland Home Birth Associations and the Eastbourne Home Birth Support Group.

In working out a schedule for the interviews, I had to consider practical constraints such as finances and the length of time I was away from my children. I arranged four sets of interviews to coincide with trips to attend New Zealand College of Midwives or half-yearly national and regional home birth meetings. This led to the interviews being spread out over more than two and a half years. By coincidence, three interviews were conducted on the 25 March, each a year apart.

Once I had decided to interview members of a particular association, I made telephone contact with a member of the committee to ask if they could find someone from their group to act as a contact person. These were all women who I knew or had met at home birth conferences. I sent information letters explaining my research to the contact person to distribute to members asking if they would be interested in participating in a group interview. I provided a choice of dates around the time of my visit to their part of the country. I left the decisions about how the interview group would be constituted, where and at what time the interview would take place to the groups themselves. I told the contact people that I would be happy to speak to whoever came along. I received feedback, however, that my letter did not attract newer members because they felt they would not have anything to contribute. I sought to address this in later interviews by discussing this issue with the contact person. The invitation letter began with the words:

This is an invitation to participate in the research project *Home Birth Associations in the 1990s*, which explores the ways in which Home Birth Associations are responding to changes in the delivery of maternity services in the 1990s.

I was primarily interested in talking to activists, rather than members who had little contact with an association's committee, but I did want to hear from women (and men) who were in the process of becoming members of

the committee of their association. However, when there was a mix of newer and more long-term members in the group interviews, the newer members tended to contribute less to discussions.

For five of the nine interviews I conducted, I also stayed with the contact person on the night before or after the interview. This was not part of my research design, but something that was offered by all the contact people I approached to arrange the interviews. I greatly appreciated this hospitality.

Most of the participants in the focus group interviews were consumers. Midwives participated in six of the interviews. When quotes from the interviews are included in the following chapters, I have indicated when midwives make a contribution to the discussion. Unless this is indicated, all those contributing to discussions are consumer members of home birth associations.

Along with the consent forms, I handed out a short questionnaire at each interview. The questions asked whether the participant was a consumer or a midwife, how long she/ he had been involved in the local association, her/ his role within the association, what other community groups she/ he was involved in and her/ his age. 32 out of 46 of these were returned. Some of this information is included in the group interview profiles in Appendix I. Overall, the youngest interview participant was 20 and the oldest was 43. In this spread of ages, one third were 29 years or younger, another third between 30 and 34, and the last third were aged 35 and over. With respect to the length of time participants had been involved in their home birth associations, eight participants had been involved with a home birth association since before 1990. Another seven had joined between 1991 and 1993. Three had become members of their local association in the year prior to the interview, while the remaining 15 had been members between two and four years.

I do not use the real names of the participants in the transcript excerpts I have included from the interviews in this thesis, nor do I give any biographical details about any specific participant. However, I realise that this does not protect the participants' anonymity from those who are familiar with the members of the associations included in the research. This is an issue which I discussed beforehand with the participants, pointing out that this thesis would be a public document. To enable participants to withdraw any of their comments which they were not happy for me to use in the thesis, I sent back copies of the interview excerpts used in the text to the contact person from that group. I considered this to be particularly important in light of the relatively small communities that association members are part of. However, no changes were asked for.

Interestingly, in several interviews, I was told that specific discussions could not be used in the thesis. Comments were made like "you will have to edit this bit out" or "we are telling you, but don't put this in". These related to details of contract negotiations, comments about specific midwives or incidents involving home births. Some of these would have been interesting to discuss in my work, but none change the basic arguments that are made. In the analysis in the following chapters, although it is always informed by my knowledge as a participant, I have explored the issues as they were presented in the interviews.

In working on the analysis on the connections between home birth association and the New Zealand College of Midwives, I realised that I needed to talk to other consumers who had been members of the national committee of the College. I conducted two interviews on the phone with women from outside Christchurch who had been consumer representatives of the home birth associations. I think the use of a telephone for interviewing was possible in these instances because we were known to each other through home birth association and College networks. I wrote notes during

the conversation.

I asked questions about what the interviewee saw as the role of consumer representatives in New Zealand College of Midwives forums and how, in their assessment, 'consumer representation' worked in practice. I also asked about their interpretations and critiques of the notion of 'partnership' between consumer organisations and the College. The number of women who have been consumer representatives of home birth associations in national College forums is very small. This makes it difficult to protect the anonymity of these participants. In view of this, I do not include any other background information, such as when they were involved or which home birth association they came from. This was discussed before they each agreed to be interviewed.

Recording and transcribing

All the group interviews were audiotaped. The individual interview with a member of Tauranga Home Birth Association was not taped at her request and I wrote down her words as she talked. The telephone interviews were also not taped. I found that note-taking in these individual interviews was easier by phone than in person. On the telephone, the flow of the conversation was not reliant on visual clues which freed me to write the words as they were spoken. I also found it seemed more acceptable to stop the person so that I could catch up with writing. They could use the pauses to think of what they wanted to say next.

Transcribing the tape recorded interviews proved to be much more difficult than I had imagined. The sounds made by babies and children made it difficult, at times, to hear what was said. Sometimes it was difficult to tell

who was speaking, especially because women often shifted positions during the interview - to retrieve a child or get more food - so differences of direction and distance could not always be used to distinguish between speakers with similar intonations and accents. In the end I do not think it has mattered as much as it might have in other kinds of interview contexts. There often appeared to be a high degree of interchangeability between speakers, a sense that the comments had been said before and represented already articulated and shared understandings within the group.

I transcribed the interviews in full, including repeated words, 'um', 'mhm', 'yeah', 'you know', pauses and so on. When I included excerpts in the text, I edited these out. In my initial drafts, the full text was used. However, I felt that the extra interpretive work this created for readers did not do justice to the ease and fluency with which the words were spoken. Therefore, comments from the interviews are edited to assist the reading and yet retain the meaning. No words were changed (except at the request of participants on being sent the a copy of the quotes I used from the interview with their group). Words that I have added, where I think a reference might be unclear, are always in square brackets. When more than four words were taken out in editing, this is denoted by '...'. Monosyllabic 'filler' indications of assent by me or other group members were also edited out, though emphatic indications of agreement or disagreement were retained. Where another speaker makes a comment which I have not included this is signified by '...' on the next line down.

Conclusion

An important consideration in my research design was to find ways to minimise the power imbalances between myself as the researcher and those who participated in the research. This reflects not only my feminist academic training, but also my position as a feminist consumer health advocate. To achieve this, I used group interviews and gave participants control over whether I could include comments that they made.

The outcome of the investigative work discussed in this chapter is explored in chapters seven to eleven. The next three chapters provide an historical overview of birthing politics, discuss the emergence of home birth associations in the late 1970s and the activism of the 1980s.

4

*The politics of birthing:
an historical overview*

The past offers us the opportunity to glimpse other possibilities, to see that the world needn't be as it is now.

Alice Echols (1995:110)

Introduction

This chapter attends to the ways in which home birth activism in New Zealand has been framed by past debates and struggles over birthing practices. I argue that home birth activists and their opponents have drawn on 'cultural resources' that are specific to reproductive issues in New Zealand in constructing contemporary politics and strategies. I am interested in the following kinds of questions. In what ways have the shifting legislative, professional, and institutional arrangements relating to the management of childbearing women and of babies opened up possibilities for particular forms of resistance, while limiting others? How are the strategies, or the 'collective action frames', deployed by New Zealand's

home birth advocates contingent on historically produced matrices of power and meaning?

Margaret Wetherell and Jonathan Potter suggest that the type of account presented here could be called a 'pre-story', because it offers an explanation of salient aspects of the present by showing how they have been constituted through past struggles (1992:105). This rests on an assumption that the past shapes the possibilities and the limits of the discourses and social positions available to social actors in the present. In constructing this pre-story, I have relied primarily on secondary sources written by feminist historians. I have particularly sought out histories of the politics of birthing which pay close attention to the details of conflicts, compromises, reversals and the unintended consequences of different collective actions. What I have found particularly fascinating is the paradoxical durability *and* fragility of the relations of power surrounding the social management of childbirth. As Jana Sawicki suggests, it is not that

... medicine has not had a monopoly over childbirth during this century, but rather that this control was not simply imposed from top down. It had to be won and continually faces resistance (1991:82).

Hilary Marland and Anne Marie Rafferty suggest that attention needs to be paid to the ways in which the histories of birthing practices are specific to each community or nation. They argue that:

... the history of midwifery has often been represented as a moral fable in which midwives struggle towards, or from, the teleological goals of increasing technology, the hospital and the professionalization of childbirth. As ... revisionist histories show, more subtle forces are at work. What is so striking is that, in spite of the universality of childbirth, its cultural expression and professional and legal regulation vary enormously across time and space, even within the context of the Western world (1997:3).

The pre-story told in this chapter can be read against accounts of the history of Western childbirth practices as an inevitable march towards medicalisation (see for example; Achterberg, 1991; Ehrenreich and English, 1973; Rich, 1977). Such accounts do not offer a way of historically locating the complexities of home birth politics in New Zealand in the 1990s that I address in the following chapters in this thesis, such as the difficulties home birth activists encounter in negotiating relations with midwives, the tensions among women who have a different orientation to birthing and the contradictory positions adopted by state actors with respect to formulating maternity service policies.

My historical account begins with the New Zealand Midwives Registration Act, 1904, which repositioned midwives as trained and registered attendants for normal childbirth. Moreover, these midwives mainly attended those women who could not afford medical care. This new generation of midwives differed significantly from their unqualified predecessors. The initiative for the Midwives Registration Act came from a midwife who was interested in raising the status of women's occupations. The government supported this act as a way of furthering its pronatalist and imperialist political agendas.

The second section of this chapter examines some of the issues surrounding the maternal and infant mortality debates in New Zealand from 1920 to 1935. The public concern over the high maternal mortality rates prompted and legitimised increased state intervention into maternity services. The leaders of the campaign for improved maternity services were doctors, working for the Department of Health, who suspected that the leading cause of women dying in childbirth could be attributed to medical birthing practices. Doctors in private practice responded by forming an organisation to ensure that doctors both retained control over their work and secured a more powerful position in influencing future government

policy. Concurrent and connected to these debates between different sets of medical practitioners, Pākehā women began demanding access to stronger forms of pain relief for birthing. They saw painless childbirth as a way to enhance their control over their birthing. It also became framed as a class issue - only affluent women could afford pain relief. These two struggles shaped the 1938 Social Security legislation, which entitled every woman to free maternity care provided by a doctor of her choice.

The third section begins with a discussion of the natural childbirth movement which emerged in the 1950s. This was centred around the national network of the Parents Centre Federation. It proved to be far more difficult for Parents Centres to achieve changes in the maternity services than it had been for the activists for pain relief. In response to Parents Centres' political lobbying, the government established an advisory Maternity Services Committee in 1961. Ironically, this committee, run by obstetricians, began to radically restructure New Zealand's maternity services in ways which led to the increasing medicalisation of childbirth. It was during the time when the power of the obstetricians who were linked to the Maternity Services Committee was at its zenith that the first New Zealand home birth associations were formed. The activism by home birth groups, and groups which grew out of the home birth movement, made a critical contribution to preventing maternity services from becoming controlled entirely by obstetricians. In the closing section of this chapter, I will signal some of the connections between my retelling of the history of maternity services in New Zealand and the issues with respect to home birth activism which will be discussed in subsequent chapters of this thesis.

Regulating Midwives, establishing an occupation

In 1904, the Midwives Registration Act was passed, and with it came the first institutional education programme for midwives in New Zealand. Over the next few years, seven 'St Helens Hospitals' were opened. They had a dual purpose. One was to serve as training schools for midwives who would be able to attend normal childbirth throughout the country. This course took 22 months to complete, although trained nurses had only to undertake the last ten months (Donley, 1986:34). The second purpose of St Helens Hospitals was to provide a state subsidised, midwifery led maternity service to cater for married women from low income families (Donley, 1986:32-33, 39; J.O.C. Neill, 1961:56-57; Parkes, 1991:166-167). This included a district service for those who wanted to have their babies at home (Donley, 1986:33, 39; Parkes, 1991:167). The Midwives Registration Act, 1904, marked the first steps by a New Zealand Government to provide a maternity service for those who could not afford private hospital or doctor care.

One of the principal objectives of the Midwives Registration Act, 1904, was to prohibit unregistered midwives from attending women in labour without the supervision of a registered medical practitioner (New Zealand Parliamentary Debates (*NZPD*), Vol. 128, 1904:73; Papps and Olssen 1997:86).¹ The Act, therefore, made 'lay midwifery' illegal. Midwives without formal qualifications, who had practiced for more than three years and were of 'good character' could get a registration if they applied before 1907 (Donley, 1986:32; *NZPD*, Vol. 128, 1904:72).

This legislation was significant in a number of respects. Firstly, it redefined

¹ Medical practitioners achieved registration in New Zealand in 1869 (Belgrave, 1991:16).

'midwife' as a legal term - as someone who was registered under the Act. Through the education programme, the Midwives Registration Act created a new kind of midwife, modelled more on the newly emerging profession of nursing than the traditional midwife. Whereas the 'new midwife' was trained and qualified and, at least at the outset of her career, likely to be young and single, the traditional midwife tended to be married and have had children herself (Belgrave, 1991:23-24).²

This legislation was primarily the initiative of one woman - Grace Neill. She drafted the Midwives Registration Bill and personally persuaded the then Prime Minister, Richard Seddon, to promote it. Neill was a trained nurse and midwife and the Assistant Inspector of Hospitals, Asylums and Charitable Aid.³ She was one of the few women to hold such a high position in the public service. Neill had also been closely involved with the drafting and implementation of the Nurses Registration Act, 1901 (Donley, 1986:30, 94; J.O.C. Neill, 1951:51-57; Tennant, 1986:37, 48-49).

Neill's project of reconstructing midwifery needs to be understood in the context of the changes which had occurred in maternity practices in Europe over the previous century. By the time the intensive Pākehā settlement began in New Zealand in the 1840s, midwifery, particularly in Britain, was on a steady decline and birth was becoming increasingly medicalised (Donnison, 1977). Between 1750 and 1850, new bourgeois standards of respectability dictated that 'gentlewomen' (which included women from the 'skilled artisan classes', many of whom had practiced midwifery in earlier

² Belgrave collated the information from the 1906 Register of Midwives and found that only 63 held a midwifery qualification and of these two thirds were not married. 662 women registered based on experience and less than ten per cent of this group were single (1991:23-24; from the *New Zealand Gazette*, 1906:1126-1130).

³ The Department of Hospitals and Charitable Aid was restructured into the Department of Public Health in 1900 (Cheyne, O'Brien and Belgrave, 1997:221).

centuries) should not engage in paid employment outside the home. As fewer of these women became midwives, midwifery became identified as an occupation primarily for poor, rural and working class women (Donnison, 1977:9-11, 36-39, 48-49, 62; Sullivan and Weitz, 1988:7; Willis, 1983:102).

Anne Witz employs the concept of a 'demarcationary strategy of deskilling' to describe how the medical profession sought to restrict and delimit midwifery practice and simultaneously establish medical practice as a superior 'sphere of competence' (1988:80-84). By the mid-nineteenth century, midwives had come to be defined as attendants for 'normal' labour. Doctors, in Witz's analysis, also pursued a second demarcationary strategy which was "to segment the market according to the social class of the client and the gender of the practitioner" (Witz, 1990:683). With few doctors interested in providing birthing services to those who could not afford to pay their fees, midwives became the birthing attendants for the poor (Donnison, 1977:151).

Women's choice of birthing attendants was divided sharply along class lines and they turned to birthing attendants from their own class and community networks. Middle and upper class women sought attendants who, while not the same gender, were from similar class backgrounds (Borst, 1995:1-12; Leavitt, 1986:8, 81-86; Sullivan and Weitz, 1988:7). Judith Walzer Leavitt maintains that middle class women themselves increasingly came to believe in the 'truth' of scientific claims and began to choose medical birth attendants in the hope that this would make birthing safer and easier (1986:79-86, 99-108). Deborah Sullivan and Rose Weitz suggest that the choice of maternity practitioners became a mark of affluence and class status. Attendance by a doctor, a man, who charged higher fees than a midwife, was seen as a "status symbol" (1988:7).

In the mid-nineteenth century in Britain, a new generation of midwives began the task of 'professionalising' midwifery and crafting a new collective identity for midwives. Jean Donnison suggests that this came out of social concern over the growing numbers of women who were not married, or were widowed, and had to (or wanted to) financially support themselves. For middle class women particularly, their choice of occupations was severely limited (Donnison, 1977:62-63). Florence Nightingale was a key leader in upgrading the training, work and image of nursing. Her efforts in the Crimean war (1854-1856) made her a national, and international heroine and inspired many women to become nurses (Donnison, 1977:67; Ehrenreich and English, 1973:53). One of these was Grace Neill who, like Nightingale, "developed a longing to get away from the stifling [upper class] family life" (J.O.C. Neill, 1961:11). By the time Neill came to New Zealand, she was a widow with a young son to support and she needed to find paid employment (J.O.C Neill, 1961:20).

Donnison notes that Nightingale wanted to improve the status of midwifery, as she had done for nursing. She even started a training programme for 'midwifery nurses', but her aim, which was never realised, was more radical for midwives than it had been for nurses. She wanted to train each midwife as a 'physician-accoucheuse', "who would be capable of attendance on all cases, normal and abnormal" (Donnison, 1977:77). Two other groups of women in London formed schools for midwives between 1865-1875 with the ultimate goal of being able to train midwives who would be as qualified and competent as medical practitioners in attending childbirth (Donnison, 1977:68-69, 74-87, Witz, 1990:684-685). They were supported by doctors who, according to Donnison, believed that doctors should not combine 'midwifery' with general or surgical medical practice, and were advocates for women's rights (Donnison, 1977:74). Other, more influential doctors within the medical professional organisations, mobilised successfully to block moves to extend the scope of midwifery practice

(Donnison, 1977:68-69, 74-87).

This struggle, according to Donnison, had several important outcomes. It increased pressure to allow women to be admitted to the Medical Register. This was finally achieved in Britain in 1876 (Witz, 1988:80). It also created a small but vocal group of educated and politicised midwives who turned their attentions to achieving midwifery registration. This struggle lasted in Britain for more than a decade as doctors mobilised against the state registration of midwives. Some hoped that midwifery would become redundant, with doctors attending all births - because complications could arise anytime and were difficult to predict. Other doctors, aware that there would not be enough doctors to attend all births in Britain, saw a role for midwives as their assistants in attending poor women for normal births. They lobbied for registration under medical control (Donnison, 1977:103-105, 117-118, 130, 140). By 1900 there was widespread public support for the registration of midwives and the Midwives Bill was passed in Britain in 1902 (Donnison, 1977:171-172).

Like the home birth movement a century later, the 'professionalisation' of nursing and midwifery was connected to an upsurge of feminist activism. Neill herself was a strong supporter of women's suffrage, but not aligned to the main group in New Zealand campaigning for this - the Women's Christian Temperance Union. Rather, J.O.C. Neill records, she was part of a group, headed by Maud Pember Reeves, who were connected to the 'leftist' Liberal Party (1961:31) who lobbied for the vote in the name of 'justice and logic' (Neill quoted in J.O.C. Neill, 1961:39). She believed that women's social position could be improved through higher education and enhanced employment opportunities (J.O.C. Neill, 1961:41). Through qualifications and registration she was seeking to secure a new professional status for nurses and midwives. In 1899, when Neill addressed the International Congress of Women, she acclaimed the success of the new

opportunities nursing had opened up for women:

In 1860 but few professions were open to women, and but little higher education or technical training available for girls. Just consider one moment the wasted lives and unhappy marriages resulting from such a condition.

In 1899 the position is altogether different. No longer have we to complain of a dearth of women eager to take up the profession of nurse. Every hospital and every training school has its list of names waiting for a probationary trial (Quoted in J.O.C. Neill, 1961:39).

Neill argued that nursing was a 'profession', requiring intelligence, skill and training, which offered women the rewards of career, and a more fulfilling marriage and motherhood - if they were to eventually marry and have children.

Anne Witz (1990) and Michael Belgrave (1991) argue that the midwives and nurses' professionalising project, based on registration and qualifications, was modelled on the professional strategies of medical practitioners. Witz, however, suggests that the concept of 'dual closure' marks the difference between these female dominated professional projects and that of medicine. By dual closure, Witz means "a two way exercise of power" - aimed at both challenging control or "occupational imperialism" by the dominant medical profession and securing the status of the profession through excluding untrained women (1990:682-687).

This highlights the other side of promoting the positive qualities of trained midwives. Like many medical practitioners interested in eliminating midwifery, the new professional midwives also denigrated the untrained or lay midwives, albeit to justify why training was necessary. Neill herself referred to "Sarah Gamps" as being "realistic sketches of their period" (J.O.C. Neill, 1961:39) while in an article for the *Evening Post*, she referred

to lay midwives who "often ruined" the health of the mother and baby through "their ignorance and uncleanness" (in Tennant, 1985:35-36, from the *Evening Post*, 1912).⁴ In the parliamentary debates over the Midwives Bill in New Zealand, it was Members' views of the 'danger' of untrained midwives that prompted them to accept the training and registration of midwives. Seddon, the Prime Minister, argued that:

It is unnecessary to point out that there are some [midwives] who indulge a little too freely, and I think the sooner we have legislation which will ensure competent midwives - sober and especially clean midwives - the sooner you will prevent loss of life (*NZPD*, Vol. 131, 1904:110).

Both in Britain and New Zealand, midwifery leaders promoted trained midwives as birthing attendants for poor women unable to afford the rates of doctors' fees (Donnison, 1977:102-103, 117, 125). They, therefore, accepted the demarcationary boundaries advocated by some medical practitioners, as well as a lower rate of pay for midwives attending births. At the same time this accommodation was an important and effective counter strategy by educated midwives to the moves by doctors to make maternity exclusively their field of practice.

The shift to the formal training of midwives meant that the relationships between working class/ rural poor birthing women and the midwives attending them in childbirth had to be reworked. Lay midwives, who came from the communities where they practiced, and had children themselves, were replaced by qualified midwives who were generally single and middle class, or at least, trained in middle class values. Marland describes these new midwives as 'health missionaries' whose role included

⁴ Sairey Gamp was a fictional character from the novel *Martin Chuzzlewit* (1844), by Charles Dickens who was alcoholic and "... setting aside her natural predilections as a woman, she went to a lying-in or a laying out with equal zest and relish" (Dickens quoted in Willis, 1983:100).

instructing lower class women about middle class ideas on personal hygiene, infant feeding and care (Marland 1997; see also Cameron in Neill, 1961:89-90, 94; Donnison, 1977:103, 128, 143-144).

The historical work by Alisa Klaus points to another aspect of midwives' bid for occupational territory. She suggests that activists in the middle class women's movement argued that, as women, they were more sensitive than men to the problems faced by poor women (see also; Tennant, 1986:48-52). They stressed women's differences from men and argued that as women, they had:

... a special interest in maternal and child welfare, and a claim to understand the needs of poor women based on a belief in the universal sisterhood of shared female experience, particularly motherhood (Klaus, 1993:285).

Margaret Tennant contends that this set up a problematic contradiction for lower class women receiving care and their more privileged female caregivers (1986:52). Their interrelationships were simultaneously constituted through discourses of commonalities based on gender, on the one hand, and hierarchical differences of class, knowledge, social practices and access to resources, on the other. Tennant contends that this contradiction has been carried over into contemporary social work (1986:52). It can also be argued that the current 'partnership model' advocated by the New Zealand College of Midwives and maternity consumer groups is an attempt to negotiate the contradictions between the midwife as 'holder of officially recognised expert knowledge' and as 'worker with women'.

In the interests of the nation: the Midwives Registration Act, 1904

The registration of midwives and the introduction of a state subsidised midwifery training programme and birthing service tied into wider ideological shifts in another important way. In New Zealand, and in most Western nations, the end of the nineteenth century saw a growing disillusionment with laissez-faire economics, while various liberal and socialist political philosophies became more popular. Reformers advocated an expanded role for the state in promoting social harmony and alleviating some of the worst effects of capitalism for the working class (Cheyne, O'Brien and Belgrave, 1997:29-30; Klaus, 1993:4-6, 282-285). This connected to new anxieties about physical and moral degeneration and white 'race suicide'. These came to be seen as 'national' problems, with racial, economic and military implications (Donley, 1986:30-33; Tennant, 1986:89). Cheyne, O'Brien and Belgrave argue that consequently: "The state's obligation to improve the health of the nation became the main justification for providing social services, influencing the kind of services provided and their extent" (1997:32-33).

Klaus argues that concerns about infant and maternal mortality were an important catalyst for the foundation of welfare state institutions in the industrial world (1993:5, 282). Seddon justified the Midwives Registration Bill with the argument that "the deaths at maternity are alarming, and I say, without hesitation, that if these proposals are given effect to, the number of deaths will be decreased" (*NZPD*, Vol. 128, 1904:71). When the Bill was introduced in Parliament, the discussion was primarily framed around infant and maternal mortality, the falling birth rate and the problems of birthing attendants for women from working class and poor 'back blocks settler' communities (*NZPD*, Vol. 128, 1904:70-91). As Donnison notes with respect

to the British registration of midwives, regulation was seen by members of parliament and some sections of the public as a way "to protect poor mothers and their infants, rather than to elevate the status of midwives" (1977:157).

The Members of Parliament who spoke to the Bill all seemed to agree that the role of the state should encompass intervening in the reduction of infant and maternal mortality and increasing the birth rate (of the white population), although several pointed out that this was "a new departure so far as the State in this colony is concerned" (*NZPD*, Vol. 128, 1904:70, see also 73, 78, 79). The Bill won universal support in the House.⁵ Seddon even commented that he could "not recollect any measure that has been received by the House with more favour" (*NZPD*, Vol. 128, 1904:88).

The Midwives Registration Act marked the beginning of the state making childbirth a subject of state intervention. This was inspired by imperialist and pronatalist concerns with respect to the reproduction of the 'settler' population - and not the Māori population. Nevertheless, Māori maternal and infant mortality rates were much higher than for Pākehā (Donley, 1986:134). Due to the combination of introduced diseases, loss of land, and the land wars, the Māori population had fallen from 200,000 - 400,000 in 1840 to 37,000 by 1900 (Fox, 1994:75-76). Until 1935, Māori health issues were managed separately from Pākehā health in the Health Department, under the Division of Māori Hygiene (Mein Smith, 1986:3).

In 1909, a Māori District Nursing programme was initiated by Māori leaders working with the Health Department. The aim was to extend Pākehā health

⁵ After this, J.O.C. Neill notes that an 'organised and determined' group of doctors who were part of the British Medical Association tried, unsuccessfully, to influence Members of Parliament to reject the Bill while it was in the Committee stage (1961:54).

services to Māori through providing registered Māori nurse/ midwives to work in Māori communities (Coney, 1993a:88, 92-92, 102-103). Sandra Coney reports that before then nurse training programmes would not admit Māori pupils (1993:92). The Māori District Nurse scheme did not fulfil the expectations of Sir Maui Pomare and others who established it. Becky Fox argues that one problem with the scheme was that Māori nurses were not sent back to their own tribal areas after training. Thus “they felt unsafe and left” (1994:76). They also met with Māori resistance to Pākehā ideas about health as well as a lack of effective support from the Health Department (Coney, 1993a:93; Donley, 1986:134).

Elaine Papps and Mark Olssen contend that the Midwives Registration Act, 1904, served to subordinate midwifery under medicine. They argue this on the grounds that midwives had to register with the Inspector-General of Hospitals, a Health Department official who, by law, was also a doctor. Furthermore, St Helens Hospitals all employed medical superintendents to be available to attend difficult cases and teach trainee midwives. The Midwives Registration Act also limited the instruments and drugs midwives could legally use (Papps and Olssen 1997:85-86). However, it is important to recognise the complexity of the relationship between medicine and midwifery. The Act did not require midwives to call a doctor when complications arose, although it was probably standard practice to do so, if a doctor was available.⁶ While the Act did not establish midwifery as a self-governing profession, midwives were still able to exercise some control over their work.

⁶ An amendment to the Nurses and Midwives Act in 1945 and the Obstetric Regulations required midwives to call a doctor in “certain abnormal circumstances” (Donley, 1986:97).

The hospitalisation of childbirth

The Midwives Registration Act, 1904, did not bring about the reduction in maternal mortality that legislators had hoped for. By 1920, these rates had actually increased. More than 150 Pākehā women died each year in the early 1920s (Kedgley, 1996:77). This sparked a series of intense debates, over the course of the next fifteen years, between doctors working for the Department of Health and medical practitioners in private practice about the causes and solutions for maternal mortality. Philippa Mein Smith (1986) documents these struggles in detail and argues that this conflict, paradoxically, served both to extend the Health Department's stake in maternity services as well as the medical profession's control over defining childbirth and obstetric practices in New Zealand.

In New Zealand, at this time, most births took place at home or in one-bed maternity homes. Mein Smith notes that in 1920, 35% of Pākehā women gave birth in hospitals, which included 4% birthing in St Helens Hospitals. This rose to 58% six years later (8% at St Helens Hospitals) and 87% by 1938 (1986:1, 62, 65). No information was collected about Māori births. Nor were statistics gathered to indicate what proportions of births were attended by doctors or by midwives working alone. Mein Smith contends that "doctor attendance was common, if not the norm, by the early 1920s" (1986:16).⁷ It is likely that the most frequent practice for Pākehā birthing women was to be attended by both a doctor and a midwife (*AJHR*, H.-31A, 1938:75).

Coney suggests that birthing Māori women were attended by women from their whānau as well as their husbands. A district nurse or a Tohunga might

⁷ The Committee of Inquiry Into Maternity Services, 1938, estimated that 75% of births were attended by doctors (*Appendix to the Journal of the House of Representatives* (*AJHR*), H.-31A, 1938:75).

be called in if there were difficulties (1993a:58-59).⁸ Fox argues that there had been significant changes in Māori birthing practices (1994:75-76). Traditionally Māori women did not birth in their homes, but made a 'whare kōhanga', a temporary birthing shelter, away from the rest of the village (Durie, 1998:15-16). As a consequence of the loss of their lands and contact with European ideas, Māori women began to birth in their own homes (Binney, 1992; Coney, 1993a:58-59).

It would appear that the number of midwives working independently of a medical practitioner did not increase after the establishment of the St Helens' training programme. Mein Smith suggests a number of possible reasons for this. One important factor was that after 1914, the state-run National Provident Fund and 'friendly societies' began to disburse maternity payments to subscribing members. This enabled more people to afford medical attendance for birthing (1986:16). Another contributing factor was the Midwives Registration Act, 1904 itself; specifically how it became translated into maternity care practices.

Mein Smith maintains that untrained registered midwives began to work more closely with their local doctors, in the capacity of labour attendants, calling in the doctor for the birth. By virtue of their untrained status, they were vulnerable to criticism - and loss of clients - and had to be cautious about their practice (1986:17). Some women, however, preferred to employ untrained midwives, even if trained midwives were available, because many would also help with domestic work after the birth (Donley, 1986:27; Mein Smith, 1986:46-47).

The Inspector of Midwives reported in 1909 that newly trained St Helen's

⁸ Tohunga were banned from practicing under the 1907 Tohunga Suppression Act.

midwives often faced difficulties in setting themselves up in independent practice, especially in the 'back blocks'. These midwives needed to establish and support themselves. Untrained midwives, the Inspector noted, were less likely to rely solely on midwifery for their income and generally already lived in the communities where they worked (*AJHR*, H-22, 1909:10). Some St Helens midwives, who were also nurses, became district nurses (*AJHR*, H-22, 1909:10). Many, however, found work in private hospitals and in the growing number of public maternity annexes which were being established by hospital boards (Mein Smith, 1986:18). Thus, few St Helens trained midwives set up as domiciliary practitioners. Instead, they were located in hospitals, or as nurses, working alongside doctors.

Maternal mortality 'panics'

Mein Smith recounts that the problem of maternal mortality was brought to public attention through two incidents. The first, in 1921, was a report produced by the Children's Bureau of the United States Department of Labor. This showed that New Zealand had one of the highest maternal mortality rates in the Western world, second only to the United States. Maternal mortality statistics had been collected in New Zealand since 1872, but it was the unfavourable comparison to other countries, which prompted the Minister of Health, James Parr, to release the report and explore avenues of remedial action (1986:7-11).

The second crisis occurred two years later when five women died from puerperal sepsis at the Kelvin Private Maternity Hospital in Auckland. Following 'a national storm of protest', the Minister of Health, Sir Maui Pomare, initiated a Commission of Inquiry into the deaths at Kelvin Hospital (Mein Smith, 1986:19-20). Mein Smith notes that the Commission was

introduced by caregivers and instruments through inadequate sterilisation. Many doctors in private practice disputed this theory. They argued that women already carried the infectious bacteria which caused sepsis (Mein Smith, 1986, 28-29, 50-55). Mein Smith notes that Jellett called this, the autogenous theory, "the 'cocoa theory', because it was 'grateful and comforting' to doctors eager to avoid culpability for puerperal sepsis" (1986:50).

The ensuing conflict between the Health Department and private practitioners became both an intra-professional struggle about the appropriate management of childbirth, and a struggle over professional autonomy versus state control over medical services. The Health Department had no authority to directly regulate medical practice or education (Mein Smith, 1986:29, 38-40). Instead officials used their statutory power over midwives and hospital licensing and their potential influence on women's birthing choices as leverage to change medical practice. Early in 1927, doctors organised a collective response to the Health Department's initiatives. They formed the Obstetrical Society which was affiliated to the British Medical Association. In the words of Doris Gordon, the founder of the Obstetrical Society, doctors needed to act collectively to counter the Department's "reign of terror" and "to refute allegations that obstetricians were a forceps-interfering, pest-bearing coterie" (quoted in Mein Smith, 1986:41).

The hygienic midwife: H.Mt 20 regulations

As midwives were registered with the Health Department, the Department could control midwifery practice. Mein Smith proposes that Department officials sought to influence medical practice by setting higher standards for

midwifery care than those generally followed by doctors of the time (1986:36, 117). In 1925, Paget and Jellet drafted a new Nurses and Midwives Registration Act which elevated midwifery training to a postgraduate course. The Act created a new official category of birth attendant - a maternity nurse (Mein Smith, 1986:36). This Act reclassified midwives registered under the Midwives Registration Act 1904 as 'maternity nurses'. Maternity nurses could only practice under a doctor's supervision and could not be licensed to run maternity hospitals (Donley, 1986:95; Mein Smith, 1986:36-37; Parkes, 1991:171). The Act also created the Nurses and Midwives Board. The Board became responsible for midwifery and nursing education and registration and the registration of hospital training programmes for nurses and maternity nurses (Dobbie, 1990:56; Donley, 1986:89).

Doctors in private practice were divided over the Government's changes to midwifery. Mein Smith notes that many avoided working with maternity nurses, suspecting that they were "departmental agents who, moreover, often knew their business better than the doctor" (1986:46; see also Donley, 1986:30). However, many doctors with a busy general practice had no choice but to work with maternity nurses (Mein Smith, 1986:47). Paget and Jellett also promoted midwives as birth attendants for normal childbirth, which many doctors saw as potentially threatening their own maternity practice (Mein Smith, 1986:31, 38, 41-43, 64).

Health Department officials and the Board of Nurses and Midwives set out new procedures to maintain asepsis for hospital births, which maternity nurses, working with doctors, and midwives were required to follow (Dobbie, 1990:11). These were called the 'General Principles of Maternity Nursing and the Management and Aseptic Techniques of Labour and Puerperium', and were subsequently referred to as H.Mt. 20 regulations. Sue Kedgley and Joan Donley describe these techniques as follows:

Upon admission, [a woman] was stripped, bathed, given an enema, (doctors were afraid that an accidental bowel movement might cause a bacterial infection) had her pubic hair shaved and was taken to a labour room (Kedgley, 1996:79).

Under the H.Mt. 20 regulations, women could no longer be delivered in labour rooms. At the crisis moment of full dilatation, they were to be transferred panting to the 'theatre' to have their cleanly shaven pubic area swabbed with antiseptics and draped with sterile linen while their 'deliverer' scrubbed up to catch the baby. Then the baby was cleaned and dressed in sterile linen before it was finally given to the mother. After the birth, each mother was panned and swabbed at four-hourly intervals - with a sterile bedpan, sterile swabs, antiseptic solution, and a scrubbed-up nurse in mask and gown (Donley, 1986:44-45).

Women were subjected to this for the ten days following a birth (Dobbie, 1990:11). The regime also included regular monitoring of women's temperatures to check for indications of infection. Maternity nurses and midwives had to notify the Health Department in all cases of a rise in temperature (Mein Smith, 1986:36). Similar procedures were followed in home births (Mein Smith, 1986:31). The H.Mt 20 regulations were in place for 35 years (Dobbie, 1990:11), but certain procedures such as bathing, shaving of pubic hair and enemas on admission to hospital were still practiced in some New Zealand hospitals in the mid-1980s.

The H.Mt 20 regime represents an attempt to take account of both the exogenous and autogenous theories of the causes of puerperal sepsis. On the one hand, these regulations were primarily targeted at changing the birthing practices of doctors and midwives. On the other, they were intense 'rituals' enacted on the bodies of birthing women. Mary Dobbie, in her history of the Parents Centre movement in New Zealand, notes that birthing women reacted to the new regulations with "a mixture of apprehension (this is an operating theatre) and relief that such great care was being taken

of them in what was obviously going to be a dangerous business" (1990:11). The application of the H.Mt. 20 procedures had a perverse effect of simultaneously inciting fear of childbirth, especially death from infection, and reassuring women that by submitting to these unpleasant and invasive techniques, this threat could be averted.

These regulations did nothing to enhance the relationships between birthing women and the maternity nurses or midwives who attended them. In interviews Kedgley conducted with women who birthed in the 1930s, they talked about the 'uncaring', 'callous' attitudes of some maternity nursing staff in hospitals. Kedgely quotes Nancy Sutherland who said of her birthing experiences in 1937; "the attitude of the hospital staff was that they were the experts, mothers were non-persons who knew nothing" (1996:80). Women who Kedgley spoke to recounted that midwives and nurses became more concerned with following institutional regulations and routines than with supporting birthing women (1996:80-83, see also Dobbie, 1990:4-8, 11; Parkes, 1991:169-170). Borst and Leavitt argue that, in the United States, the introduction of new standards of obstetrics, combined with increasing hospitalisation, changed the relationship between medical practitioners and birthing women considerably (Borst, 1995:11-12; Leavitt, 1986:189-195, 206-207). Borst proposes that:

For physicians who wished to practice obstetrics, new obstetrical standards superseded those that had granted community physicians professional authority in the early twentieth century. With professional status increasingly based on new institutional structures within medicine, physicians turned away from patients and to their peers for approbation (Borst, 1995:11-12).

The hospitalisation of childbirth in New Zealand appears to have had similar effects. Midwives and maternity nurses working in hospitals became more attuned to the 'approbation of their peers' than that of birthing

women. A potent mix of the new regimes, combined with the existing hierarchical structures within hospitals, the rivalry between midwives and doctors, and a belief in the superiority of medical expert knowledges profoundly shaped the relationships between midwives and women birthing in hospitals. The move to hospitals pushed the contradiction inherent in the midwifery professionalising project in the direction of 'health missionary' rather than working 'with women'. At the same time, Dobbie points out, the regulations strengthened the position of midwives in relation to the medical profession. She comments that it "was a protection for nurses and midwives against medical criticism. They could no longer be held responsible for medical carelessness" (1990:11).

The Department of Health and the Obstetrical Society

Through licensing, drafting regulations, and inspecting hospitals, Health Department officials could exert control over hospital standards (Mein Smith, 1986:22, 30-34). Department of Health officials revised regulations concerning building standards, staffing, equipment and record keeping for private hospitals offering a maternity service. The reforms included extending the powers of Department inspectors to revoke licenses for private hospitals which were unable to comply with the new standards and to temporarily close hospitals when a case of puerperal sepsis was suspected (Mein Smith, 1986:36, 57-59). Many of the private hospitals were owned by doctors. The new hospital regulations fuelled the antagonistic relationship between doctors in private practice and those in the Health Department.

Mein Smith points out that the key officials initiating the Health Department reforms were medical practitioners and this shaped the ways in which the

problems of maternal welfare became defined, as well as the kinds of solutions which were proposed. They focussed on the prevention of infection and on the personal health services delivered by doctors and midwives. Those factors which were considered more as 'social' problems, such as poverty, poor housing and nutrition, were largely ignored by both the Health Department and medical organisations (1986:53-54).

To reduce the comparatively high rate of maternal mortality, Health Department doctors attempted to use their central state positions to raise the standards of medical services. This was something which the New Zealand Branch of the Medical Association had been unable or unwilling to do. In a sense Paget and Jellett were trying to correct the failure of professional self-regulation. According to Mein Smith, Jellett argued for the necessity of his involvement in the Health Department because there was no Chair in Obstetrics and Gynaecology at the University of New Zealand in Otago to ensure that doctors were adequately trained in obstetrics (1986:39-40). Jellett was committed to developing a single standard obstetric service. As one of the few specialist obstetricians in New Zealand, he set about trying to effect this, both through his work for the Department and through his own research and lecture tours (Mein Smith, 1986:70-80).

Doctors in private practice interpreted the Department's campaign as a threat to their professional autonomy and right to free trade. To protect these interests, doctors employed the strategy of collective action and formed the Obstetrical Society. Paget and Jellett had not, however, moved to bring in state regulation of the medical profession. Instead they used increased surveillance of private hospitals and improved training for the rival maternity practitioner - midwives - to encourage doctors to improve their own standards of practice. Members of the Obstetrical Society challenged certain aspects of Jellett's ideas about the causes of puerperal

sepsis and appropriate levels of interventions in birthing, but they did not necessarily dispute the concept of scientific medicine and a single standard obstetrics. The Obstetrical Society's position was that this needed to be determined by the profession and not by doctors working for state agencies (Dobbie, 1990:11; Mein Smith, 1986:42, 45, 46).

Paget's and Jellett's campaign achieved the aims of reducing maternal mortality. In 1932, New Zealand "earned worldwide acclaim for producing the lowest death rate from puerperal sepsis following childbirth" (for the Pākehā population) of all the Western countries collecting similar statistics (Mein Smith, 1986:66). The safe maternity campaign did make doctors more reflexive about their practice, which was the form of 'control' the Health Department sought (Mein Smith, 1986:73). At the same time the Obstetrical Society became a powerful interest group. Mein Smith argues that by the mid-1930s their influence in shaping New Zealand's maternity services, and even Government policy, surpassed that of the doctors working within the Health Department (1986:86-87, 90-91, 119).

The Health Department did have another reform agenda which angered the doctors in the Obstetrical Society. In anticipation of a stronger role for the Health Department in planning and managing New Zealand's maternity services, Paget, Jellett and other doctors in the Health Department explored different ways of rationalising New Zealand's maternity services to improve access, standards and cost efficiency (Mein Smith, 1986:45). Like Neill, thirty years earlier, they advocated a midwifery service for normal births. As Mein Smith explains:

Both Paget and Jellett favoured domiciliary midwifery for normal births. The former, being of a practical disposition, advocated home births because they were cheaper, but Jellett's Rotunda Hospital background led him to believe domiciliary attendance by midwives produced better results because midwives were expected to adopt a uniform

aseptic technique (1986:31).

Moreover, they believed that midwives were more patient and less likely to see a need for interventions, such as forceps, to hasten delivery (Mein Smith, 1986:44). In support of this contention Paget and Jellett cited the statistics of St Helens Hospitals, which consistently had the lowest rates of maternal mortality and interventions (Mein Smith, 1986:63, 72, 78). The Obstetrical Society were alarmed about the reduced role for general practitioners in birthing that such a scheme would entail (Mein Smith, 1986:54).

Paget and Jellett had different ideas about how to develop a hospital system for those women who required medical assistance for birthing. Jellett advocated a system of large public maternity hospitals in the main centres which would also serve as research and teaching institutions for midwifery and medical students. Jellett had another intention - to oust general practitioners from maternity practice. He believed that ideally, women should be attended by midwives for normal births, and by specialist obstetricians, like himself, for difficult births. He considered general practitioners to be insufficiently skilled to assist with complicated deliveries, and dangerous because they potentially spread infection from other patients (Mein Smith, 1986:60-62). Paget, on the other hand, preferred a network of small maternity hospitals all over the country, with a more important role for general practitioners (Mein Smith, 1986:34-35). These debates, about the relative merits of many small hospitals versus fewer, larger teaching hospitals, arose again in the 1960s and 1970s when obstetrician gynaecologists sought to secure more control over New Zealand's public maternity services.

Pain relief for birthing

The vision of a comprehensive domiciliary midwifery service for normal births was never realised. One of the reasons for this failure was the attraction of sedation and pain relief in labour for Pākehā women. Under the nursing and midwifery regulations, midwives, working without doctors, could only offer chloroform. However, many birthing women found this to be ineffective. To access stronger pain relieving drugs, women needed to seek medical birth attendants and birth in hospitals (Donley, 1986:40-42; Ebbett, 1981:114-116; Mein Smith, 1986:84-85, 87, 137).

In part, women's demands for pain relief reflected a medical interest in pain relieving drugs after development of 'twilight sleep' in Germany in 1902.⁹ This was a combination of morphine or nembutal and scopolamine or hyoscine. The primary effect of these drugs were that they induced amnesia. Women could not subsequently remember their birthing experiences (Donley, 1986:40). Donley comments that twilight sleep could promote relaxation and shorten labour, although if it was administered too early, it could stop labour altogether. At the same time, women needed to be restrained when under the influence of twilight sleep, because they sometimes became irrational and a danger to themselves. Consequently, the practice of strapping women to the bed became common (Donley, 1986:40; Kedgely, 1996:85-87; Leavitt, 1986:127-131; Smith, 1938:155-158). This led to increasing use of interventions such as induction, forceps and caesarians (Mein Smith, 1986:71, 81).

Twilight sleep created controversy amongst medical practitioners. Some doctors, including those working for the Department of Health, were critical

⁹ Twilight sleep was introduced in New Zealand by the outspoken and popular doctor, Doris Gordon. She began to offer it to women at her private hospital in Taranaki in 1918 (Donley, 1986:40, Kedgely, 1996:85).

of twilight sleep. They argued that it increased the need for intervention, posed risks for both the mother and the baby, and would accelerate the trend toward hospitalisation (Mein Smith, 1986, 71, 82-83). There was opposition to using anaesthesia in labour from other medical practitioners based on the passage in Genesis, 3.16; "In sorrow thou shalt bring forth children".¹⁰ Eve Ebbett quotes a leading obstetrician in Wellington, in the 1930s, who denied a woman's request for pain relief, telling her; "Eve gave Adam the apple and she should pay for it" (1981:115). The women who were demanding pain relief were effectively rejecting these Biblical ideas.

In the second half of the 1930s, a number of women's organisations began to lobby for stronger pain relief to be available for women birthing at St Helens and public hospitals. These groups included the Women's Auxiliary of the Unemployed Workers' Union, the women's branches of the Labour Party (Coney, 1993b:246) and the Family Planning Association of Auckland (Dobbie, 1990:14). A representative from the Women's Service Guild argued to the Commission of Inquiry into Abortion in New Zealand that the fear of childbirth and lack of pain relief led some women to seek abortions (Brookes, 1976:29). Coney notes that 35 women's groups sent a deputation to the Minister of Health in 1938 calling for more pain relief in childbirth (1993b:246).

Women's groups framed their demands for stronger forms of pain relief in childbirth as an issue of class inequalities. Only women who could pay for private hospital care were assured of having twilight sleep (Mein Smith, 1986:85). In Britain, demands were also made by, and on the behalf of, working class women for access to pain relief for birthing (Williams,

¹⁰ Jean Achterberg reviewed archival texts written by European midwives and found that pain relief was never mentioned. She suggests that midwives did not (openly) use herbal pain relief because they were forbidden to do so by the Church (1991:121).

1997:124-146). A. Susan Williams, in her study of the National Birthday Trust, includes a quote from a letter to a popular British magazine in 1942 which expressively sums up these politics of pain relief. A woman wrote that:

One of the most cruel class divisions yet remaining in this country is that rich mothers need not suffer in childbirth as though we were still in the Stone Age, while poorer ones far too often do (1997:143).

In a similar vein, Donley describes Vera Ellis-Crowther, a St Helens trained midwife, as:

... an early feminist who struggled for better conditions for working class women before the days of state subsidised maternity care. She saw one of those 'conditions' as being able to afford 'twilight sleep' as their 'exalted sisters' had (1992a:18).

For these women, pain relief represented medical and humanitarian progress, and they were making a claim for pain relief to be seen as a woman's right, irrespective of ability to pay.

Consolidating medicalised childbirth

The increase in women's activism around pain relief in the second half of the 1930s was connected to the election of the Labour Government in 1935 (Dobbie, 1990:13; Donley, 1986:46). One of the first steps this government took in relation to reproductive issues was to set up a Committee of Inquiry into Abortion in 1936. While New Zealand had one of the lowest mortality rates for sepsis following childbirth, it also had the highest mortality rate for septic abortion of all the Western countries which collected such statistics (*AJHR*, H-31A, 1938:8). The many women's groups who made submissions

to the committee used it as an opportunity to lobby for birth control, economic support for the poor, including free maternity services - and readily available pain relief (Brookes, 1986:126-136; *AJHR*: H-31A:8-19). This prompted the Minister of Health to establish a second inquiry - the Committee of Inquiry Into Maternity Services - to investigate whether New Zealand's maternity services were "satisfactory and adequate" (*AJHR*, H.-31A, 1938:66). The Committee members included four doctors and three women nominated by the National Council of Women. The Committee members travelled extensively around the country to hear evidence and make inspections of antenatal and postnatal services, public and private hospitals, as well as the extent to which pain relief was available for birthing (*AJHR*, H.-31A, 1938:67).

The Committee of Inquiry into Maternity Services made recommendations to the government about the future organisation of maternity services. Their recommendations, Mein Smith contends, show that the power to direct New Zealand's maternity services had passed from the Health Department to the Obstetrical Society by the late 1930s (1986:119-120). The majority of the committee accepted the view of childbirth put forward by the Obstetrical Society - that birth was always potentially abnormal and pathological and thus required hospitalisation and the presence of a doctor (Mein Smith, 1986:42-43).

The committee recommended a 'combined service' for maternity care, whereby birthing women were attended by both a doctor (usually a general practitioner) and a maternity nurse (*AJHR*, H.-31A, 1938:73-76). The report suggested that "the doctor exercises general supervision of the first and second stages and is present at the delivery", while the maternity nurse would "spend the hours of waiting in the first and second stages of labour" and call the doctor when she thought delivery was imminent (*AJHR*, H.-31A, 1938:75). They suggested that if some form of social insurance were to

be introduced, it should cover a combined service such that a women could "have the services of the doctor of their own choice" (*AJHR*, H.-31A, 1938:76). On the subject of pain relief, the committee was divided as to whether it should be more widely available considering the risks associated with its use. It recommended the adoption of the "fullest degree of pain relief consistent with the safety to mother and child" (*AJHR*, H.-31A, 1938:87-90).

Two of the four doctors on the committee, Paget, now the Health Department's Director of Maternal Welfare, and Silvia Chapman, the Medical Superintendent of Wellington's St Helens Hospital, tabled 'reservations' to the report. They argued for the Health Department's position that doctors were not necessary for birthing and that midwives were fully competent to attend normal births. In response to women's demands for more pain relief, Paget and Chapman called for more research into safer forms of anaesthetics than twilight sleep, and suggested that these could be administered by well-trained midwives (*AJHR*, H.-31A, 1938:112).

If Paget's and Chapman's views had been accepted by the committee, New Zealand's maternity services would have followed the British model. In 1936, the British Government passed the Midwives Act, aimed at extending access to maternity care for those who could not afford, or did not wish to pay for, medical attendance. This Act established a nation-wide system of salaried domiciliary midwives, with time off, annual leave and a pension, which was part-funded and administrated through the local authorities (Donnison, 1977:191-192; Williams, 1997:67-68). However, there were major differences between birthing practices in New Zealand and Britain. In England and Wales midwives attended 60% of all births and 75% to 85% of births were at home (Williams, 1997:50). By contrast, in New Zealand, by the 1930s, more than 80% of women birthed in hospitals and most were

attended by doctors (*AJHR*, H.-31A, 1938:76). These differences themselves were an unintended outcome of the Health Department's safe maternity campaign and the effective countermobilisation by doctors who felt threatened by the Health Department's power. For this reason, Mein Smith argues that the changes to New Zealand's maternity services over the decade from 1925-1935 were more significant than those that followed with the election of the Labour Government (Mein Smith, 1986:118-119).

The Committee of Inquiry into Maternity Services also looked into the situation regarding Māori births. They noted that in 1937 only 17% of Māori women had their babies in hospitals and the Māori maternal mortality rate was almost twice the Pākehā rate (*AJHR*, H.-31A, 1938:126). The Committee suggested that this was due to the inability of 'Native' attendants to deal with 'emergencies' and 'overcrowded' and 'insanitary' conditions found in many Māori villages (*AJHR*, H.-31A, 1938:127). Although the Committee recommended more district nurses to work in Māori areas, they argued that Māori women should also birth in hospitals. Thus, they recommended:

... that the same general policy of hospitalization of maternity cases should be developed for the Maoris as for the European mothers; indeed, the arguments in favour of this course of action might be regarded as even more cogent owing to the inability of the Native domiciliary method to meet serious emergencies (*AJHR*, H-31A, 1938:97).

This recommendation was supported by Māori Members of Parliament, who interpreted them in terms of a step in the direction of honouring broken land sale promises of "free doctors, hospitals and schools" (Mr Tirikatene, *NZPD*, 1938:526-528). However, in their submission to the Maternity Services Committee, Taranaki Māori representatives asked for separate Māori maternity hospitals. They wanted Māori to have access to a maternity service which combined the best of Western and Māori birthing practices

(Donley, 1986:125). The Committee did not accept this and suggested instead that:

It is accordingly recommended that in all Maori districts provision should be made in the local public maternity institutions for the admission of Native patients and that sympathetic consideration be given to their customs.

It is suggested that, as far as possible, separate wards should be provided (*AJHR*, H-31A, 1938:97).

This marked the transition to social policies based on the explicit assimilation of Māori into Pākehā culture. By 1962, 95% of Māori women were birthing in hospitals. The Māori maternal and infant mortality rates still continues to greatly exceed the maternal and infant mortality rates for Pākehā (Donley, 1986:122, 132).

In 1938, the Labour Government passed the Social Security Act which provided New Zealanders with free hospital services and subsidised medical services, financed through general taxation. This was done through a schedule of various benefits, and significantly, the maternity benefit was distinct from other hospital benefits and the general medical subsidy for general practitioner consultations. Each benefit was negotiated separately and priority was given to settling the maternity benefit, which was achieved in October, 1939. The maternity benefit itself was made up of a number of different benefits covering doctors, midwives, public, private and St Helens Hospitals.¹¹ Providers filed claims to the Social Security Fund for each individual client for whom they provided a service. Except for specialist obstetricians and some private hospitals, maternity service providers were prohibited from charging additional fees from their clients (*AJHR*, H.-31,

¹¹ In the 1939 maternity benefit schedule, doctors received £5/5 (\$10.50), which included four antenatal visits and the birth. Domiciliary midwives could claim up to £5/10 (\$11.00) for birth attendance and fourteen postnatal visits (*AJHR*, H.-31, 1940:7; Donley, 1992a:35-36).

1940:6-8).

In bringing in the maternity benefit, the government implemented the major recommendations from the Maternity Services Committee. Birthing women became entitled to free maternity care provided by a doctor of their choice, and free hospital services - including pain relief (*AJHR*, H.-31, 1940:7-8). The maternity benefit schedule also covered the costs of home births attended by 'obstetric nurses'. These could be either independent midwives or maternity nurses supervised by a doctor (*AJHR*, H.-31, 1940:6-7). The schedule for obstetric nurses did not cover antenatal care. A woman who wanted to birth at home with a midwife had to go to a doctor or a hospital clinic for antenatal care. The maternity benefit, thus, helped consolidate medical control over childbirth services by positioning doctors as the arbiters of which pregnancies and births were, or were not, progressing as 'normal'.

The medical maternity benefit scale of fees had to be negotiated between the Minister of Health and the Council of the New Zealand Branch of the British Medical Association (later the New Zealand Medical Association) (*AJHR*, H.-31, 1940:7). There was, however, no nominated body to negotiate the benefits paid to domiciliary midwives. This would later serve as an impetus for the formation of the home birth associations and the New Zealand College of Midwives (Donley, 1992a:32).

The Parents Centre natural childbirth movement

In the 1930s, most women's groups interested in maternity issues lobbied for access to pain relief. However, even at that time, other women became interested in 'prepared' natural birth. Influenced by the writings of Grantly

Dick-Read, they were particularly concerned about the amnesic effects of twilight sleep (Dobbie, 1990:14-16). As an alternative to sedation and pain relief, midwives at St Helens Hospitals introduced antenatal relaxation and breathing classes in 1938, and in 1939, Beryl Service established a Certificate in Obstetrical Work as an option at the School of Physiotherapy in Dunedin (Coney, 1993a:60; Dobbie, 1990:16, 20). But the majority of doctors, who were now in charge of New Zealand's maternity services, did not support these initiatives and pain relief came to be administered routinely in most hospitals (Dobbie, 1990:14-16; Kedgely, 1996:87).

In the early 1950s, some women again began to question the hospital management of birth, demanding natural childbirth and antenatal childbirth education. In 1951, a group of women in Wellington came together and formed the Parents Centre antenatal education movement.¹² They were interested in the ideas of the Christchurch Psychological Society who promoted prepared natural birth and home birth, fathers' support during birthing, rooming in, and breastfeeding. Parents Centre activists promoted natural birth to give parents and babies a good start to their relationship, and they established antenatal classes where women could learn breathing techniques to cope with pain and facilitate a 'natural' childbirth (Dobbie, 1990:1-3, 17-25, 34; King, 1990:29-30).¹³ The Obstetrical and Gynaecological Society (formerly the Obstetrical Society), the Nurses and Midwives Board and the Plunket Society's professional leadership opposed their demands. In part, these professional interest groups saw the Parents Centre demands as a threat to their control over technical aspects of their work from a women's organisation (Dobbie, 1990:23).

¹² They initially called their group the Natural Childbirth Association, but changed the name to Parents Centre because it was "less provocative" and signalled the group's commitment to enabling fathers to be at the birth (Dobbie, 1990:21).

¹³ The second Parents Centre was opened in Palmerston North in 1954, the third one formed in Christchurch in 1956. By 1964, twelve Parents Centres had been established in different parts of the country (Dobbie, 1990:33-34, 36, 99).

In 1958, Parents Centre activists found an important ally in medical circles. This was Professor Harvey Carey, the Head of the Postgraduate School of Obstetrics and Gynaecology at the Auckland Medical School and Medical Director of the National Women's Hospital in Auckland. Carey was a strong advocate for antenatal education to help women overcome their fear of childbirth. He was also critical of the twilight sleep form of pain relief, the inflexible H.Mt. 20 regulations and the prohibitions on mothers and babies rooming in after birthing (Dobbie, 1990:42-44, 51-55, 64-67; Donley, 1986:73-76, 84).

Dobbie outlines that Carey saw an important political role for Parents Centres - to mobilise public support for changes he was trying to institute - and a practical role in being able to offer "more relaxed and friendly" antenatal classes than those given by hospital staff (1990:43, 52, 80). Consequently, he opened the possibility for Parents Centres to be recognised by the British Medical Association (New Zealand) as an 'ethical medical auxiliary' - the same status accorded to the Plunket Society. He advised the Parents Centre Federation executive that, to be accepted by the British Medical Association, Parents Centres would need to make a number of changes to their policies and structure. These included ceasing to publicly support home birth and "inviting suitable doctors of high standing" to form a medical directorate for the Federation who would approve the 'medical' content of the classes and any publications and press releases (Dobbie, 1990:53-54).

The Parents Centre executive decided to comply with Carey's recommendations in order to be able to reach more women through doctors' referrals.¹⁴ Parents Centres needed to forge links with doctors, if

¹⁴ Other leaders in the British Medical Association strongly objected to Parents Centres' views and blocked granting ethical status until 1961 (Dobbie, 1990:60, 63-64, 78; Donley, 1986:85).

women were to be able to arrange a natural birth in a hospital. While women could choose a supportive doctor, they could not choose the hospital staff who attended them in childbirth. Women who had taken the Parents Centre classes continually encountered hospital nursing staff who would not support their efforts to have a natural birth (Dobbie, 1990:44).

While negotiating for ethical status, Parents Centres became caught up in a struggle over the H.Mt. 20 regime and the training of nurses. The rigid adherence to the H.Mt. 20 regulations by maternity nurses was a significant obstacle to the reforms in hospital procedures which Parents Centre activists were seeking.¹⁵ The Nurses and Midwives Board staunchly defended the H.Mt. 20 regulations and threatened midwives, maternity nurses and hospital training programmes with deregistration if they did not comply with them (Dobbie, 1990:51, 56, 66; Donley, 1986:90).¹⁶

In 1957, major changes were made to the training of nurses. Flora Cameron, the Director of the Division of Nursing in the Department of Health and a member of the Nurses and Midwives Board, introduced a new curriculum for general nurses which included maternity nursing (Dobbie, 1990:56; Donley, 1986:99-100; Papps and Olssen 1997:126). A response from birthing women to the new nursing curriculum was prompted by a women's group from a small town in the South Island - the Oamaru Mothers' Group - who sent a letter of complaint to all members of the National Council of Women. Their primary concern was that first year trainee nurses sometimes administered anaesthetics and even conducted deliveries. They wrote; "Where, may we ask, have the interests of the

¹⁵ The problem of puerperal sepsis had largely been solved with the advent of antibiotics after the second world war. However, a bacteria resistant to the antibiotics available at the time, commonly known as the H-bug was prevalent in many hospitals (Dobbie, 1990:42).

¹⁶ Donley notes "no one seemed to remember" that these regulations had been designed by Health Department doctors in 1925 (1986:90).

mother been consulted in this matter?" (Dobbie, 1990:62). The Wellington Parents Centre took up the Oamaru Mother's Group complaint and put a remit to the National Council of Women calling for a governmental inquiry into the regulations covering maternity services, particularly training hospitals (Dobbie, 1990:56).

Some doctors were also lobbying for the H.Mt. 20 regulations and nursing education to be reviewed, though this was not necessarily out of a commitment to natural childbirth. Rather, Donley and Dobbie contend, this was bound up with protecting their professional interests (Dobbie, 1990:42; Donley, 1986:99-100). Carey, for instance, wrote to Parents Centre Federation executive, criticising the H.Mt. 20 regulations because:

... as a matter of principle, ... a doctor should be able to prescribe the treatment he considers best for his individual patient, instead of being tied to a rigid and outmoded policy laid down by a few elderly nurses and midwives (quoted in Dobbie, 1990:65).

With respect to the inclusion of maternity in general nurse training, Carey and other doctors argued in a letter written to the *New Zealand Medical Journal* in 1960, that on account of the new nursing curriculum "medical students, our future obstetricians, have difficulty in getting deliveries" (quoted in Donley, 1986:100).

Under pressure from Parents Centre, the Wellington Branch of the National Council of Women, formed a sub-committee - on which three of its five members came from the local Parents Centre. The committee prepared a report documenting the views of consumers, nurses and doctors who advocated maternity service reforms. Their report caused deep divisions within the National Council of Women (Dobbie, 1990:62-72). Flora Cameron, who was also in the National Council of Women, saw this as a bid for the medical control of nursing and considered the consumers' views

recorded in the report to be those "of a few disgruntled people" (Dobbie, 1990:65-66). Some nurses believed the report deserved some consideration, because nurses, as providers of a tax funded service, should be accountable to taxpaying consumers, but these were in a minority (Dobbie, 1990:66-68).

In 1961, the government responded, not with an inquiry, but through establishing the Maternity Services Committee of the Board of Health. This committee's members were all professionals involved in maternity services, including representatives from nursing and different branches of medicine. Parents Centre activists unsuccessfully lobbied for the inclusion of a consumer representative (Dobbie, 1990:70-71). The Maternity Services Committee was an advisory committee which could make recommendations on policy directions to the Minister and Department of Health (*Maternity Services Committee*, 1982:2). It became a powerful voice for obstetric specialists, who made up half of its members (Coney, 1988:19; Donley, 1986:65, 116; *Maternity Services Committee*, 1982:1; *NZPD*, 1960:3400). Soon after, the Nurses and Midwives Board was restructured and lost the power to determine obstetric regulations (Donley, 1986:90-91). The protests from Parents Centres about aspects of maternity nursing training and practices did not open up opportunities for women to have a natural birth in hospitals. Rather, Donley contends, obstetricians used this consumer dissatisfaction to advance their own struggle to undermine the Nurses and Midwives Board (Donley, 1986:89).

The regionalisation of maternity services

In the 1960s, a new group of doctors began to seek control over the structure of New Zealand's maternity services. This was the New Zealand

Council of the Royal College of Obstetricians and Gynaecologists, lead by obstetricians from the Postgraduate School of Obstetrics and Gynaecology at the University of Auckland.¹⁷ Using the Auckland National Women's Hospital as a model for New Zealand's maternity services, they argued that all births should take place in centralised, specialised hospitals, and that smaller maternity hospitals should be closed (Dobbie, 1990:123-4; Donley, 1986:60-64). Donley comments that:

Ironically, no sooner had doctors finally established that state maternity care was going to be under their control and in hospitals, than they were in turn challenged by the arrival of specialist obstetricians and gynaecologists (1986:49).

The obstetricians' moves to restructure New Zealand's maternity services were significant in several ways. They changed the role of GPs, forced the closure of a number of small maternity hospitals and reduced women's choices in birthing still further.¹⁸ It also incited a countermobilisation by some consumers of birthing services and some midwives to challenge the growing medical monopolisation of childbirth services.

Obstetricians from the Royal College of Obstetricians and Gynaecologists not only advocated that all births should take place in hospital where obstetrical cover was available, they also asserted that GPs should not attend deliveries (Dobbie, 1990:104, 124; Donley, 1986:61, 63, 111).¹⁹ Like

¹⁷ The Royal College of Obstetricians and Gynaecologists formed in Britain in 1929. In 1946, fifteen fellows were registered in New Zealand (Donley, 1986:59). By the mid-1960s, there were 79 registered fellows in New Zealand (Donley, 1986:60).

¹⁸ I will now use the abbreviation 'GP' which came into common usage around this time to refer to family doctors, as other specialities of medicine grew in strength and power. In doing this I am following Donley (1986) and Williams (1997) who shift to using the abbreviated form in their historical narratives from 1960 onwards.

¹⁹ Donley (1986:110-111) outlines a series of reports produced in the 1970s which advocated regionalisation and closure of small maternity facilities. These included the R.C.O.G. *Medical Graduate Needs for the Years 1968-2000* (1970), *Maternity Services in New Zealand* by the Maternity Services Committee (1976)

the Health Department officials in the 1920s and 1930s, the Royal College obstetricians argued that GPs were inadequately trained to attend childbirth. However, this new breed of specialist obstetricians did not agree with Jellett's contention that childbirth was a 'normal physiological process' for 80-90% of birthing women, and that consequently, specialist hospitals were only needed for the minority who might encounter complications in birthing (Mein Smith, 1986:33, 81). Rather, they asserted that "childbearing is not the normal physiological event with few problems many people assume" (Prof. Mantell, quoted in *Auckland Star*, 2 October, 1978:16).

A key figure behind this campaign against GP maternity care was Dennis Bonham, who became the Chair of the School of Obstetrics and Gynaecology at the University of Auckland in 1963 (Coney, 1988:20; Donley, 1986:76). A. Susan Williams suggests Bonham left England under a cloud because his criticisms of home births, which at that time were much more common in Britain than in New Zealand, angered many GPs (1997:217).²⁰ Obstetricians faced a major obstacle to their attempts to remove birth from GP care. This was the Social Security Act, which granted every birthing woman "the right to select her medical practitioner" (s. 106 cited in *Maternity Benefits Tribunal*, 1993:11). The New Zealand Council of the Royal College of Obstetricians had to use other strategies to achieve their aims. One was the 'Bonham Squeeze', which entailed reducing the numbers of 'open beds' for GPs to book birthing women in specialist obstetric units, while ensuring a reduction in the numbers of small maternity hospitals, where women were attended by GPs (Dobbie, 1990:123-124; Donley, 1986:61-63). Bonham recommended that only "healthy women under thirty", having their "second, third or fourth babies only" should be

and *The Development of Obstetric, Gynaecological and Associated Services in Auckland* (1972) by the Auckland Hospital Board.

²⁰ Bonham later achieved notoriety in New Zealand through the Cartwright Inquiry, 1988.

allowed to be booked into a maternity hospital (*New Zealand Home Birth Association National Newsletter*, Vol. 2, No. 2, 1984:21).

Obstetricians, in 1980 initiated the formation of a Medical Council Obstetric Standards Review Committee to set guidelines for the conditions a GP had to meet to be eligible for a contract to practice in hospital board facilities (Donley, 1986:50-51, 115). The obstetricians lobbying for regionalisation sought to limit GPs maternity work to normal births, such that GPs had to transfer women with complications in birthing to the obstetric 'team' (Maternity Services Committee, 1982:42-44). Obstetricians employed the same 'demarcationary strategy of deskilling' with respect to family doctors as doctors had used in relation to midwives two centuries earlier to confine them to attendance for normal births.

Relocating births in obstetric base hospitals, with their large complement of different staff and students, technologies and hospital routines, made it even more difficult for women to be involved in making decisions about their care. Some women were angered about many standard practices in base hospitals, for example; 'daylight obstetrics', where women were induced to ensure the baby would be born during the day when more staff were on, the routine use of electronic foetal heart monitors and episiotomies, the presence of students during the birth, and babies being placed in nurseries and given formula - all without being asked to give their consent (Kedgley, 1996:239-241). On a political level, the policy of regionalisation was pursued without consulting consumers, or heeding their complaints (Donley, 1986:110-113). Donley quotes from a 1980 Auckland Area Health Board report advocating the regionalisation of maternity services, which stated that; "it is considered vital that the body responsible for the overall implementation of a rational regional service does not allow itself to be diverted from its purpose" (1986:113).

Nurses and midwives were also making changes to their work and education. In 1971, the Nurses and Midwives Act was renamed as the Nurses Act (Donley, 1986:16). Under this new legislation, domiciliary midwives could no longer attend home births without a doctor accepting professional responsibility to oversee the care. Donley argues that domiciliary midwives:

... were required to work under medical supervision, they were accountable to doctors. Their status [was] now effectively that of a maternity nurse, and they [were] firmly locked into the nursing profession. ... The domiciliary midwives were the birth attendants most affected by the 1971 Nurses Act (1986:16).

Consequently, the number of home births (funded through the maternity benefit) dropped from 87 in 1971 to 24 in 1972 (Maternity Services Committee, 1976:78).

These changes to midwifery were part of an international movement to upgrade nurse education to keep up with the increasing specialisation of medicine. In 1971, the government commissioned a report on the training of nurses and midwives in New Zealand - known as the Carpenter Report, after the doctor who wrote it. Helen Carpenter recommended that midwives needed to be familiar with "the advances in medical science and technology" (quoted in Donley, 1986:102). On Carpenter's recommendation, nursing education began to shift from hospitals to technical institutes in the mid-1970s. The technical institute trained nurses became known as comprehensive nurses and they could study further for Advanced Diplomas. Midwifery education became an 'option' in the Advanced Diploma in Maternal and Infant Nursing. In 1979, the St Helens Hospital midwifery programmes were discontinued (Donley, 1986:101-103; Papps and Olssen 1997:126).

Donley maintains that the focus of midwifery training in New Zealand was changed from learning the skills to attend normal births, to preparing midwives to become a member of an obstetric team. This new direction for midwifery education was designed to train midwives who would work in regionalised maternity services (1986:101-103). The New Zealand Nurses Association supported regionalisation on the grounds that large base hospitals, located in the same cities as the technical institutes where midwives were trained, facilitated access to the clinical practice components of the diploma (Donley, 1992a:8-10, 102).

The Maternity Services Committee and the Royal College of Obstetricians and Gynaecologists promoted regionalisation on the grounds that it would save money and improve training opportunities for doctors and nurses. It was also approved of by a number of hospital boards, who were more influenced by demands from obstetricians, than by those of GPs and domiciliary midwives who practiced outside of hospital board areas of responsibility (Donley, 1986:111-113).²¹

Many women's groups were concerned about hospital closures and the reduction of GPs involvement in obstetric practice. This included numerous local action groups, focussed on saving a particular hospital, and national organisations, such as the National Council of Women, the Country Women's Institute and Plunket Committees (Dobbie, 1990:123-126, 127; Donley, 1986:111-112). Although Parents Centre Federation was the primary group advocating natural childbirth, they were constrained from taking the lead, as they had done in 1960, in opposing the regionalisation policies. The medical directorate which monitored Parents Centres' medical and political policies included Bonham and other obstetricians lobbying for more centralised maternity services (Donley, 1986:82-85; Dobbie, 1990:75-

²¹ Kedgely notes that "Plunket's Karitane hospitals, 29 rural hospitals and the Salvation Army's Bethany hospitals, were all closed in the 1970s" (1996:240).

78, 106, 110, 123-132). Nevertheless Parents Centre representatives worked in coalition groups lobbying against hospital closures (Dobbie, 1986:123-124).

As a consequence of the implementation of regionalisation policies, a small but growing number of people began to consider birthing at home.²² Donley, who began to practice as a domiciliary midwife in Auckland in 1974, contends that:

... with the systematic closure of these [cottage, private and rural] hospitals ... women were being subjected to increasing medicalisation of childbirth. In response, home births increased among those who were aware of this option and could stand up to the social and medical opposition (1992a:3, see also Donley, 1986:81-82).

Home birth was still a legal option and state funded under the Social Security Act, 1938, with a maternity benefit schedule for domiciliary midwives. There were however only a few domiciliary midwives practicing in New Zealand and most GPs would not attend home births either. Nonetheless, some leading obstetricians became concerned about this renewed interest in home birth. They began voicing their disapproval of home birth in public forums and at medical conferences. Donley contends that this was the impetus behind the formation of the New Zealand Home Birth Association in 1980 (Donley, 1992a:3-6; Donley and Hinton, 1993:278).

²² Donley indicates that the numbers of women birthing at home who were attended by a domiciliary midwife contracted to the Health Department recorded during these years are; 176 in 1977, 289 in 1978, 320 in 1980 (1986:81). This does not include home births attended only by a doctor, nor does it include those where no claim for a maternity benefit was made, for example, births attended only by lay midwives or family members.

Conclusion

By the 1970s there were major barriers to accessing the home birth option in New Zealand. A number of interlocking factors contributed to this. Firstly, as a consequence of birthing decisions made by earlier generations of women and of various government policies, almost all births took place in hospitals. It had become a widely shared assumption that this was the most appropriate place to give birth. This meant that there was no continuous home birth tradition in New Zealand. Despite two decades of efforts by the Parents Centres' natural childbirth movement to secure a professional and public acceptance of the principle of choice for birthing women, the choices in birthing available to women were decreasing by the 1970s. Midwives' training was being increasingly directed toward obstetric nursing and assisting doctors. The Nurses Act was changed in 1971 making GPs the gatekeepers to accessing a home birth. Finally, obstetricians had gained important controlling positions throughout the policy making and service delivery divisions of New Zealand's maternity services. These obstetricians lobbied for all births to occur in base hospitals, and in the longer term, for an end to GP maternity practice. They publicly voiced their disapproval of home birth.

Amidst all these constraints, there were, however, important facilitative conditions for the emergence of the home birth movement. These include the interprofessional rivalry which began with the entrance of male medical practitioners into the birthing room. This 'flared up' at various times around different issues with respect to birthing and continued to be a potential source of tension throughout the changing arrangements of maternity services. Home birth advocates and midwives became 'natural' allies, both because of the gendered hierarchies in maternity services, and because midwives were positioned as attendants for the 'normal' end of the birthing

spectrum. The state in New Zealand had entered into maternity services regulation and funding on the assumption that free maternity services would ensure that women had more children and healthier children for the 'good of the nation'. At the same time, this drew the state into an uneasy relationship with the medical profession in order to ensure that doctors would provide these state funded and regulated services. Home birth advocates could take advantage of these contradictions and conflicts to press their political demands for better access to home birth services.

5

'New Birth': the emergence of the home birth movement in New Zealand¹

... within movements, actors self-consciously practise in the present the future social changes they seek. Collective actors are 'nomads of the present'.

John Keane and Paul Mier (preface to Melucci, 1989:6)

Introduction

In this chapter, I examine the emergence of the New Zealand home birth movement and the home birth associations in the late 1970s and early 1980s. Drawing together writings by and about home birth activists of this time, my own recollections as a home birth activist and insights from social movement analyses, I tell a story of the beginnings of this movement and the context in which it developed. This introduces some of the agendas which will be developed in my analysis of the interview material in later chapters on New Zealand home birth associations in the 1990s. I argue that

¹ 'New Birth' was a suggested title for a home birth journal that the New Zealand Home Birth Association considered publishing (*New Zealand Home Birth Association National Newsletter*, No. 4, 1981:16).

the origins of the movement significantly shaped it over the next two decades. The chapters that follow examine how the group identity of home birth association participants has changed in response to the greater public and institutional acceptance of the movement's goals - as well as the resources and limitations generated by the particular strategies pursued by early home birth activists.

I use Alberto Melucci's notion of a 'submerged network' to examine how the people who wanted to birth at home and the midwives who attended them developed a home birth movement, a politicised collective identity and constructed alternative understandings of 'normal' childbirth. I continue with a discussion about the tensions that emerged between creating alternative and submerged cultural spaces, and activism aimed at opening up a public space through media and political campaigns. The final section analyses the public debates about home birth in the late 1970s and early 1980s in the media of newspapers, magazines and home birth newsletters. I argue that the home birth activists sought to represent birth at home as a 'right', as a 'responsible' decision and as 'empowering' for women.

Creating home birth networks

A key question for many social movement theorists has been how to account for the emergence of social movements (McAdam and Snow, 1997:2). Sidney Tarrow asserts that: "If social movement research of the last two decades has shown anything, it is that grievances are not sufficient to trigger collective action ..." (1992:177). Instead, according to social movement theorists such as Jo Freeman (1983), Doug McAdam (1994:43-45) and Tarrow, (1992:54-57), the emergence of a social movement hinges on preexisting face-to-face networks through which people get drawn into

challenging collective action. Freeman terms these 'communication networks' and argues that they also have to be 'cooptable', in the sense that movement leaders can use these networks to mobilise participants to support new insurgent goals. Friedman and McAdam argue that: "Typically, emerging movements grow out of and remain dependent upon established institutions and organisations" (1992:162).

The growing interest in birthing at home in New Zealand in the 1970s was not linked to any one existing social network or organisation.² The women and families who sought out home births came from diverse backgrounds. Some women chose home births following a negative hospital experience or in response to the closure of their local hospital (Dobbie, 1990:123; Donley and Hinton, 1993:278-279). Other women were influenced by feminist politics and viewed the medicalisation of childbirth as a form of 'patriarchal control' of women's bodies, which high technology hospital maternity units epitomised (Abel and Kearns, 1991:826; Donley, 1992a:3). There was also a growing 'alternative lifestyle' movement, that rejected the technological and institutional control of human bodies. Toni Church, from Auckland, addressing the United Women's Convention in Christchurch in 1977 explained:

Interest in home deliveries appears to have come from two sources - the move towards naturalness and away from technocratic medicine, and secondly, the growing awareness and self-confidence of women which makes

² Carolyn Noble suggests that the 'homebirth' movement in New South Wales, Australia grew out of Parents Centres Australia in the early 1970s (1997:110-111, 118). Parents Centres in New Zealand did not, as an organisation, publicly support home births, although Mary Dobbie notes that some Parents Centre leaders and members did as individuals (1990:93; see also letters to the editor Mary Dobbie, *Auckland Star*, 3 August, 1976; Nancy Sutherland, *Christchurch Press*, 30 October, 1982). Interestingly, in 1969, The Auckland Parents Centre made a film about two home births to demonstrate the physiotherapy techniques promoted by Parents Centre. Unfortunately the camera was faulty and the film *Birth - the Beginning* could not be used (1990:93-93). A full list of newspaper articles reviewed for this thesis is included in Appendix III.

many of us demand a more humane and dignified way of giving birth, and undoubtedly this stems from the Women's Movement (Church, 1978:33).

Other women, who were not necessarily feminists or interested in an alternative life style also turned to home birth. These included women who were fundamentalist Christians as well as women who came from the Netherlands or Britain, where there was a stronger home birth tradition. There were also some women connected to Parents Centres who chose to birth at home.³ It is important to note that relatively few Māori women were involved in these emerging networks. There is very little documented evidence of Māori women's interest in home birth until the 1990s. Sally Abel and Robin Kearns note that in 1987-88 only 2.7 of the total 'official' home births were to Māori women, while Māori make up 12% of the population (1991:826-827).

The diversity amongst women/ families seeking out home births suggests that the movement did not arise out of a preexisting network, and, instead it drew in women from a number of social networks. Melucci's argument that social movements should be thought of as networks of small groups which are constituted through face-to-face interactions and 'submerged' in daily life provides a fruitful way to describe the early home birth movement in New Zealand. Melucci suggests that while the 'professionalised nuclei', or the formal organisation/s of the movement may achieve a certain amount of stability, the wider network is more fluid and fragmented. Individuals may be members of a number of these network groups, facilitating the circulation and exchange of information (1994:127). The small groups are relatively transitory, participation is often temporary and is usually a part-

³ See Tully, *Auckland Star*, 7 June, 1976; *Central Leader*, 6 March, 1979; King, 1990:26-28; Donley, 1992a:20-21. This diversity was also demonstrated in the many birth stories that were printed in home birth newsletters from about 1983 onwards where women explain their various motivations for choosing or planning a home birth.

time activity (1985:800-801; 1989:60; Mueller, 1994:236-237). Thus, we can conceptualise the home birth movement as a multiplicity of overlapping informal networks of women/ families who are linked through a domiciliary midwife and a shared interest in home birth. Some of these women (and occasionally men) become members of more formal home birth support groups and the home birth association committees. For most, their commitment is transitory, but a few make longer term commitments to home birth organisations. In this thesis I am primarily interested in the 'professionalised nuclei' of the movement - the home birth associations, but it is important to bear in mind that these associations are not the sum of the movement.

There were several important conditions that facilitated the development of 'solidarity ties' between women who were birthing at home. In most home birth groups, women met through their connection to the particular domiciliary midwife, or midwives, providing home birth services in their area. Midwives and women often formed strong emotional ties through sharing the experience of birthing at home. This was based on mutual dependence and trust in the context of a shared understanding that home birth was a special intimate experience and that the home birth option was potentially under threat, opposed by certain influential sectors of the medical profession. During the 1980s, this personal relationship with individual midwives was an incentive for many women to become involved in home birth networks. In the 1990s, there was no longer this interdependence between home birth midwives and birthing women. As I discuss in chapters seven and eight, some home birth activists I interviewed argue that this makes it more difficult to maintain an active membership.

To understand the emergence of the home birth movement, attention also needs to be paid to the distinctive aspects about the transition to motherhood that have historically pushed some women to break their

isolation in the home and join groups of other similarly situated women. This has been important for the formation of a variety of women's organisations, such as the Women's Christian Temperance Movement in the 1890s (Bunkle, 1980:59-60), the Plunket Society from the 1920s onwards (Giddings, 1993:265-267), Parent Centres (Dobbie, 1990:17-25) and La Leche League (Heritage, 1993:274-276) in the 1950s and 1960s. Allegiance to other women interested in home birth formed at a point where many women, on entering motherhood, had become detached from some of their previous activities and social networks. This facilitated the formation of new friendships and new forms of connection between women who were all engaged in mothering or planning parenthood.

Home birth groups were formed during a time of heightened interest in challenging collective action in New Zealand. Sandra Coney argues that a wave of new women's health groups came into being in the 1970s, many of them "focusing on a single issue" and "part of a loosely defined 'women's health movement'" (1993b:241; see also Dann, 1985:81-84). Tarrow applies the term 'cycles of protest' to describe such periods of increased collective action. Public expressions of protest, Tarrow suggests, inspire others to reframe problematic aspects of their situation in political terms and encourages them to mobilise collectively to achieve change (1994:153-170). This, too can account for the emergence of the home birth movement in New Zealand. Not only did it follow on from the formation of similar movements in Australia and the United States, as Church suggests, many who sought out home births were already involved in, or identified with other social movements (1978:33).

The first two formal organisations of the contemporary home birth movement began in Auckland and Christchurch in the mid-1970s, with formal groups being established in Christchurch in 1976 and in Auckland in 1978 (Donley, 1992a:3). Both these groups formed around the midwives

who attended women at home for childbirth.⁴ In May, 1980, the Auckland home birth group organised a national conference. More than 150 people from different parts of New Zealand attended and it was decided to form a national organisation - the New Zealand Home Birth Association (Donley, 1992a:11; *New Zealand Home Birth Association National Newsletter*, No. 2, 1980:15). In seven other areas, there was enough local support to establish branches of the incorporated New Zealand Home Birth Association.⁵ The New Zealand Home Birth Association focussed on political lobbying to promote and protect the home birth option (*New Zealand Home Birth Association National Newsletter*, No. 4, 1981:7).

Home birth as cultural innovation

Melucci offers an intriguing approach to investigating the emergence of social movements. He suggests that before social movements mount public campaigns, individuals come together in 'submerged networks' which he likens to 'laboratories' of cultural innovation (1989:35). Submerged movement networks, according to Melucci, are hidden from the view of

⁴ One midwife in Christchurch and two midwives in Auckland took up domiciliary midwifery contracts with the Health Department in 1974 (Donley, 1992a:3, King, 1990:3). By 1978 there were ten contracted domiciliary midwives in New Zealand, which increased to nineteen by 1981. Over half of these practised in Auckland (Maternity Services Committee, 1983:18).

⁵ The initial New Zealand Home Birth Association branches were in Auckland, Waikato, Tauranga, Taranaki, Manawatu, Wellington, Nelson, Christchurch and Dunedin. In 1981, there were no domiciliary midwives practicing in Tauranga and Dunedin, although in Dunedin a few GPs attended home births (*New Zealand Home Birth Association National Newsletter*, No. 4, 1981:1-3, 17). In the following year the domiciliary midwife in Whanganui (Taranaki) gave up domiciliary practise and the Taranaki Branch dissolved. In the course of the year, new branches had formed in Northland and Thames (*New Zealand Home Birth Association National Newsletter*, No. 6, 1982:14). This became an ongoing pattern through the 1980s as groups emerged and dissolved, and domiciliary midwives came and went. At the high point of home birth activism, there were about 30 home birth groups in different areas of New Zealand (*Home Birth National Newsletter*, Summer 1990-1:21)

authorities and the wider public. This enables the individuals involved in these networks to collaborate in constructing new knowledges, new kinds of social arrangements and social practices which can be turned into collective challenges to dominant cultural codes of everyday life (1989:29-30, 35, 56-60, 90). Melucci is interested in the 'prefigurative' or 'nomadic' politics of social movements (1989), where movement participants strive to conduct their lives and intramovement relationships in ways which are consistent with their ideals of the "desired community of the future"(Echols, 1995:114, see also, Bernstein, 1997:534).

While Melucci tends to valorise social movements as 'cultural laboratories' and sites of resistance to totalising forms of power, he also attempts to avoid a "radical constructivism" or overstating the degree of agency that can be exercised within these movement networks. He assumes that individuals are the instituted effects of prior actions who, in their interactions within movement groups, question the preconditions of a particular selection of these actions. The experimentation in submerged networks is, thus, contingent on "the possibilities and limits recognized by actors" within the wider matrices of power they are contesting (Melucci, 1995:61; see also; 1985:792-795; 1994:111-114; Taylor and Whittier, 1995:172).

Ann Swidler provides an interesting way of extending Melucci's analysis. She argues that the ways of organising action in everyday life do not necessarily rely on or even closely relate to the meanings attributed to them, because they are taken-for-granted and "have the undisputed authority of habit, normality and commonsense" (1986:281). To contest these or prompt others to reevaluate familiar strategies of action, social movements need to develop a comparatively more highly articulated and explicit meaning system. These emergent discourses draw on and rework dominant cultural codes as well as incorporating new symbols (1986: 278-282). She explains:

The agendas of many social movements revolve around such cultural recodings. Indeed, since most movements lack political power (this is precisely why they use unconventional political tactics) they can reshape the world more effectively through redefining its terms rather than rearranging its sanctions (1995:34).

The notion of a 'submerged network' captures, I think, the sense of innovation and experimentation in the emerging home birth movement in the 1970s and early 1980s. It is particularly applicable to the home birth movement, in which those who participated in the submerged home birth networks were positioned outside the networks of official power in maternity services, and also the site of birthing - at home - was by definition 'submerged' from direct surveillance by authorities and elites. Before I discuss the ways in which these submerged networks produced alternative discourses and practices surrounding birthing I want to elaborate on Melucci's ideas that conflict within movement networks is productive.

Melucci argues that, in the context of conflicts with opponents, the close face-to-face interactions within the submerged network prompt participants to make strong emotional commitments to each other and hence to the collective identity of the movement in which they participate. A collective identity, Melucci suggests, is an "interactive and communicative construction, which is both cognitively and emotionally framed through active relationships" (1995:45). This collective identity is always 'in process' because it has to be continually reproduced or renewed through the repeated interactions among the participants of the network groups (1989:33-35, 217; 1994:127-128).

Melucci's approach to analysing social movements has recently been taken up by feminist social movement theorists such as Carol Mueller (1994), Arlene Stein (1995) and Verta Taylor and Nancy Whittier (1995). Their particular interest in Melucci's notion of collective identity centres on the

role of conflicts in the construction of collective identities. Melucci argues that collective identities are forged through a nexus of two lines of conflict. The conflicts between movement participants and those they challenge pushes movement actors to form ties to each other which celebrate their difference from those outside the movement. However, this brings to light the tensions and differences among movement participants (Melucci, 1995:54, 60-61). This second point has particularly interested Mueller (1994) and Stein (1995:144-146) as these kinds of intra-group conflicts have characterised the feminist organisations they study. In his later work, Melucci argues that just as the external conflicts are productive for social movements, these internal conflicts can also have positive effects. Mediating these internal differences increases the "elasticity", the self-reflexivity, the range of cultural resources movement participants can command, and hence the "irreducibility" of social movement challenges (1995:53-55, 60-61).

These ideas are interesting in relation to analysing the emergence of a collective identity among home birth networks in New Zealand. As I suggested above, women who became involved in home birth networks came from a variety of positions and attached a range of different meanings to 'home birth' and yet developed a shared sense of being different from women who birthed in hospitals. The differences among network participants were an endless source of potential conflict, for instance, between feminist women seeking to reclaim childbirth from patriarchal control⁶ and women who wanted to follow Frederick Leboyer's or Michel

⁶ For example; "Barbara Macfarlane and Deryn Cooper initiated the formation of the Auckland HBA. When asked what prompted them, they replied 'the personal is political' and explained that their motivating force was anger - anger at the powerlessness of women being forced into the medical model. ... Both saw home birth as a focus of women-power. They also saw the midwife as 'the source of ancient and authentic knowledge which is impossible to resist'" (Donley, 1992a:3).

Odent's ideas about childbearing.⁷ While there was a certain shared commitment to 'natural birth', there was not necessarily agreement over how this was best achieved. Some women advocated the use of breathing techniques or birthing in water or homeopathics, while others rejected even such benign interventions.

These difference among home birthing women impeded the construction of a new hegemonic definition of childbirth within home birth networks. It also put pressure on domiciliary midwives, who wanted to maintain a practice, to be tolerant of, and work with the particular meanings and desires each woman and her family attached to birthing. It also increased their stocks of knowledge with respect to options and alternative information that they could then offer other women. It pushed home birth network participants to define 'home birth' as an opportunity for women/parents to take control and responsibility for the birth of their babies. However, as I discuss later in this chapter and in the other chapters, these differences have at times become unsustainable, particularly during public and political campaigns to protect home birth services.

In the early days of the new tide of interest in home birth, what the midwives and women were doing was not just 'having a home birth' - they were experimenting and constructing what 'home birth' was in New Zealand. This was centred around constructing alternative, non-medicalised practices for birthing and new ways of mediating the relationships between individual women/ families and individual midwives and doctors.⁸ As one

⁷ As an antenatal class facilitator in the late 1980s, I often had to mediate in class discussions between participants engaging in this debate, and a whole host of other controversies.

⁸ The 1971 Nurses Act made it illegal for domiciliary midwives to attend home births without a doctor's supervision. This did not necessarily mean that the doctor actually had to be present during labour or at the birth. Many doctors who agreed to book home birth clients felt a professional obligation to attend for the birth. Most GPs practicing in New Zealand before 1990 refused to book home

writer in the national newsletter comments: "The current movement back to home confinements shows a questioning of childbirth as a medical 'phenomenon' and also a consciousness by women to regain 'power' in the birth situation" (*New Zealand Home Birth Association National Newsletter*, No. 4, 1981:13).

Home births had become a rare occurrence in the 1960s and early 1970s. The lack of an established home birth service, where new midwives could learn from experienced domiciliary midwives, meant that fewer midwives and GPs felt prepared to attend births at home, and those who did sometimes received intense criticism from their hospital based peers (Donley, 1986:105; 1992a:12; *New Zealand Home Birth Association National Newsletter*, No. 6, 1982:11-12).⁹ At the same time, this absence of already codified home birth knowledge and practices and isolation were facilitating conditions for the emergence of a 'submerged' home birth network. It opened up opportunities to remake 'home birth' and intensified the sense of experimentation. Carolyn Young, a midwife who began attending home births in Auckland in 1974 (Donley, 1992a:1) reflects on the ways in which attending home birth changed her midwifery practice as follows:¹⁰

birth clients. There were, however, a few doctors who were enthusiastic about home birth and important advocates for the movement.

⁹ It is important to note that there was not a *complete* lack of an established home birth culture. Both in Christchurch and Auckland there were several domiciliary midwives who attended a few births a year. These were all older midwives who retired in the 1970s. However Ursula Helem and Joan Donley, the first of the midwives who began to practice in the 1970s, had contact with these older midwives (Donley, 1992a:3, 19; King, 1990:6). One of these midwives was Vera Ellis-Crowther in Auckland, who had campaigned for access to pain relief for birthing in the 1930s and later became involved with Parents Centre (Dobbie, 1990:14; Donley, 1992a:18-19).

¹⁰ The first of the new domiciliary midwives connected to the emerging home birth movement in Christchurch, Wellington and Nelson have told similar stories of 'learning' about home birth from birthing women (see respectively; *Christchurch Home Birth Newsletter*, Vol. 10, No. 9, 1990:6; *New Zealand Home Birth Association National Newsletter*, No. 4, 1981:6; *Home Birth National Newsletter*, Autumn/ Winter, 1991:20-22).

"I started off with very hospital thinking. My first patient cleared me of a lot of hang-ups of sterility. She put her teacup on my instrument table in the middle of a contraction. It threw me completely - but she didn't die of the plague."

"I went out for a while with Joan [Donley]. We both had the fear indoctrination from hospitals so strongly. There was a standard rule that if a woman hasn't delivered within a certain time limit she automatically has a forceps delivery. After some time standing with a woman [at home] going beautifully we had reached that point and I thought, 'What now? She had had that hour' - and it suddenly occurred to me to say, 'who has the right to say women should be delivered within an hour?'" (Pauline Ray, *NZ Listener*, 15 March, 1980:22).¹¹

I contend that this pattern of learning about home birth and 'normal birth' through reflexive midwifery practice had a significant effect on the relationships which formed between midwives and consumers at home. It opened possibilities for negotiating more egalitarian relationships as midwives together with birthing women were engaged in questioning the 'preconditions' or the taken for granted strategies of action as these were defined by medical discourses about childbirth.

The 'unlearning' talked about by Young and other domiciliary midwives practicing in the 1970s and 1980s should not be confused with an outright 'rejection' of everything midwives were taught in their training. Part of why midwives were (and still are) sought out by women to attend births was because of their knowledge of possible complications and the actions that might be of assistance. However, as Donley argues, midwifery training had become increasingly focussed on "learning to depend on and use technology" and teaching midwives that "birth was not a normal

¹¹ It is interesting to note that Young talks about reexamining some of the practices for maintaining strict asepsis - the special function accorded to midwives by Jellet and Paget from the New Zealand Department of Health in the 1920s (Mein Smith, 1986; see also chapter four of this thesis).

physiological function at all" (*New Zealand Home Birth Association National Newsletter*, No. 6, 1982:5). As the comments from Young above demonstrate, domiciliary midwives had to question how much of the 'knowledge' gained from their training was appropriate for attending childbirth under the circumstances of a commitment to natural childbirth outside of a hospital. They had to work out when, from this perspective, medical interventions could be beneficial, in other words, when a woman's birthing process deviated from the bounds of 'normal'.¹²

The goal of this experimentation was to enable midwives and birthing women to be able to exercise more control over the 'socially produced potential for action' with respect to the practices surrounding 'normal' births. This was, and continues to be, one of the most troubling aspects of home birth for many obstetricians.¹³ This new direction in home birth entailed a shift in the locus of control over childbirth practices, with midwives and birthing women and home birth GPs, rather than obstetricians, defining the conditions when medical intervention would be appropriate. As I outlined in chapter three of this thesis, this has surfaced as an issue for doctors at various times from the beginning of their entry into maternity services.

¹² An Auckland University statistical analysis of the 1159 officially recorded home births in New Zealand between 1974 and 1982 found the transfer rate in labour was 7.5%, and 3.6% following the birth. The infant mortality rate was 0.35% with no maternal mortality (*New Zealand Home Birth National Newsletter*, No. 8, 1983:17-18; Donley, 1992a:60-61). A more recent retrospective study of the Aotearoa/ New Zealand Home Birth Association statistics for almost 10,000 home births between 1973-1993 found a perinatal mortality rate of 2.97 per 1000. This was compared to almost 30,000 low risk births at National Women's Hospital where the perinatal mortality rate was 2.34 per 1000, which is not a significant difference (Gulbransen et al 1997:87-88). Graham Gulbransen points out that women who would not be obstetrically classified as low risk, for example younger and older women, and women with previous caesarean, multiple miscarriages or terminations, also choose to birth at home (1997:89)

¹³ This will be discussed in more detail in the next chapter. A recent expression of this position can be found in Malpas, et al, (1997) where they argue that decisions about which women should be allowed to birth at home needs to be determined by obstetric guidelines.

There were, certainly, some crucial constraints on the degree of 'experimentation' that could be undertaken in home births. Women who choose to birth at home and their midwives had to tread what could sometimes become a fine and contested line between trying out alternative practices in their 'reconstruction of home birth' and avoiding those which might turn out to be risky with potentially emotionally traumatic consequences in terms of birthing outcomes. Furthermore, the continuation of a state funded home birth service was by no means assured and while home births occurred in the privacy of people's homes, there were indirect institutional forms of control on home births.

Until 1990, it was necessary for women who wanted to birth at home and domiciliary midwives to maintain good relationships with the GPs who booked home births to ensure their continued support (Donley, 1986:15-17; Strid, 1987:15). Only doctors, and not domiciliary midwives, were funded under the Maternity Benefit Schedule to provide antenatal care.¹⁴ The domiciliary midwives were also legally accountable to the Department of Health, under their contractual obligations for claiming the maternity benefit, and to the Nursing Council, the registering and disciplinary body for midwives. When a woman transferred to a hospital during labour or following the birth, the midwife's and the doctor's decisions could be scrutinised by the specialists and the midwifery staff at the hospital. Also, in the event of an infant or maternal death, health professionals could, and still can be, investigated for manslaughter under the Section 190 of the Crimes Act (*New Zealand College of Midwives National Newsletter*, Issue 7, 1997:20). In this respect all home births have been, and still are, potentially subject to the surveillance of state sanctioned monitors of professional

¹⁴ Domiciliary midwives could only claim for one antenatal visit until 1984, when it was increased to three. Prior to this, midwives often made more antenatal visits without being paid for them (see; Scott, *The Press*, 25 September, 1976; Ray, *NZ Listener*, 15 March, 1980:22-24; Donley, 1986:16, 20).

practice.¹⁵ Nevertheless, in the majority of home births, domiciliary midwives spent many hours attending women in labour without any direct supervision. Accountability to birthing women and their families was immediate and face-to-face.

The threats of increased statutory constraints on women exercising choice with respect to home birth added to the sense of urgency and necessity for engaging in collective action. It also intensified the emotional solidarity ties between midwives and birthing women and led to creative initiatives by home birth consumers which served to draw women interested in home birth into the networks. This is illustrated in the following comment by Hannah who participated in the group interview with the Tauranga Home Birth Association. In Tauranga at the time to which she refers, there was no domiciliary midwife working in the area. Therefore, the home birth association would try to arrange for midwives to come to Tauranga from other regions according to demand.

Hannah: The only way you could get a home birth was to be involved with the association. ... They knew all about how you go about having your baby at home. ... I went through the Association and found the midwife. There were three of us all pregnant and due within four weeks of each other. And she came down from Thames and stayed for a month or three weeks or something for these deliveries. ... We brought her vegetables and brought her food and [inaudible word] her car and were really nice to her. ... And I had [my baby] at home and really did it. I had this really amazing birth at home.

(Tauranga Home Birth Association interview, 25 March 1996)

¹⁵ GPs were obliged to follow the Obstetric Standards Review Committee of the Medical Council list of 'indications for specialist referral' if they wanted to maintain their access contracts for booking hospital maternity beds (*New Zealand Home Birth Association National Newsletter*, No. 2, 1980:7; No. 4, 1981:3; No. 6, 1982: 6). Several doctors who attended home births in the early 1980s had their access agreements revoked (Donley, 1992a:12, 39-40).

Domiciliary midwives in the 1970s were only funded to provide one antenatal visit, thus reducing the opportunities for birthing families to 'get to know' the domiciliary midwives and prepare for a home birth. In most areas, therefore, home birth association members organised information meetings and support groups, and later, antenatal classes, where families planning home births could meet the midwives and meet other women who had birthed at home (Donley, 1986:16-17). As an activist involved in the early days of the Christchurch Home Birth Association explains:

Tilda: What we were doing with our group is we had information evenings and antenatal classes and they gave you the feeling you were part of a group, ... in contact with other women having home births and having that sense of support and why you were doing it and that it was a radical thing and needs commitment.

(Individual interview, Christchurch, 31 May, 1998)¹⁶

Once they made connections with other women, these often became important in themselves. As Tilda elaborates:

Tilda: More important than midwifery care in some ways was being with other women, because of the empowerment thing, so many things the group provided - the social thing, the support and that sense of community. It was so important - for me anyway - and I suppose I'm saying it should be important for all women. One midwife has so much influence, too, over women and women build up that loyalty too - but you need exposure to lots of women and all their experiences and having things happening to them, and validating your experiences. All these different experiences and similar - opening your mind to other - hearing other women talk - opens you to other potentialities which expand your perspective. And you

¹⁶ All names of interview participants are pseudonyms.

can't get that from a practitioner.

(Individual interview, Christchurch, 31 May, 1998)

The home birth movement networks had another important focus. One impetus for many parents choosing a home birth was the belief that birth is a major life event which can have profound significance for the future wellbeing of mothers/ parents and the child.¹⁷ Thus, attention to mother and children's future lives also entered the agendas of the movement. Planning a home birth was often just the first step in reevaluating dominant cultural ideas about mothering/ parenting. The network groups offered home birth women a source of support to help cope with the added ambivalences and uncertainties generated by the continual questioning of mainstream childrearing practices. Women who had planned a home birth, but needed to transfer to a hospital, also sometimes participated in these network groups.¹⁸ I will explore the role of this kind of mutual support for alternative approaches to mothering in home birth groups today in more detail in chapter eleven.

Home birth collective identity and conflicts

Home birth midwives were important catalysts for the formation of the first home birth groups in New Zealand in the late 1970s (see for example;

¹⁷ The newspaper article which covered the formation of the Auckland Home Birth Association, for instance, discusses how home birth enhances 'bonding' between the parents and the baby (Elder, *Auckland Star*, 16 August, 1978).

¹⁸ Domiciliary midwives often tried to stay with women when they transferred to a hospital, if women wanted them to, and the midwives provided postnatal care following discharge from hospital (see for example; Ray, *NZ Listener*, 15 March, 1980; Morrison, *New Zealand Times*, 11 April, 1982).

Donley, 1992a:3, 45, 71).¹⁹ This had two important effects on the home birth movement. Firstly, it prompted activists in the New Zealand home birth associations to lobby for better working conditions for domiciliary midwives.²⁰ This drew the home birth associations into conflicts and compromises with state agencies. At the same time, another consequence was that there were marked local variations among home birth groups which led to conflicts between home birth associations.

Birthing women formed strong allegiances to their local domiciliary midwife, and the orientations of particular home birth groups tended to be related to those of the midwife who facilitated their initiation. This was discussed in an individual interview I conducted with Tilda, an early Christchurch Home Birth Association member:

- Rea: I've been reading Joan's stuff about the beginnings of the home birth association and the Christchurch support group started before that. Do you think it was different here?
- Tilda: You read Joan Donley and she has a real political edge to her, but Ursula [the domiciliary midwife in Christchurch] wasn't kind of political in that sense - and because both groups formed around the midwife, it took on that tenor. It reflected the interests and the outlook of the midwife. Ursula was a pioneer too, but Joan had that strong political focus. They both started

¹⁹ This was also the case in Wellington. A few home birth groups, however, were set up in areas where there were no domiciliary midwives available to attend home births, for example in Tauranga, Dunedin and Gisborne (Donley, 1992a:73, 74). These groups lobbied the Health Department and the local hospital boards to provide a domiciliary midwifery service. They would also sometimes organise for a midwife to come in temporarily from another area, or assist women in going to areas where home birth was available. However, these groups often struggled to survive (*New Zealand Home Birth Association National News/letter*, No. 4, 1981:1-2, 15).

²⁰ Initially activists lobbied for higher rates of payments under the midwives maternity benefit and the reinstatement of direct entry midwifery training programmes. By the mid 1980s, changing the legislation to allow domiciliary midwives to practice without the supervision of a medical practitioner and for domiciliary midwives to provide antenatal care were added to the political claims advanced by home birth associations (see Donley 1992a; 1992b).

around the same time. Our focus was on support both for the midwives and the women. We bought equipment - like for the birth and her pager. But also support for the women who were entering into that choice. It became more political later when the hospitals closed or about Ursula and submissions.

(Individual interview, Christchurch, 31 May, 1998)

Jeanette King notes that the first 'formal' home birth group in New Zealand was initiated by women in Christchurch to support each other during pregnancy and after the births of their babies:²¹

The Christchurch Home Birth Association was formed around September 1976 by Stephanie Perrott and Brenda Chain. ... Called the Christchurch Home Birth Support Group until 1983, its initial aim was to provide a forum for like-minded people to meet and give support to each other. Stephanie remembers that having a home birth at that time was an isolating experience especially when dealing with groups like Plunket (*Christchurch Home Birth Association Newsletter*, Vol. 10, No. 5, 1990:13).²²

This group formed around an understanding that women or families who choose to birth at home had specific needs and concerns which were not being met through existing groups and health care providers.

The Auckland Home Birth Association was formed in 1978 and was from its beginnings an explicitly political lobby group (Donley, 1992a:3-6). The first New Zealand (Auckland) Home Birth Association newsletter announced that the association "had been formed to protect home births as an alternative to hospital birth" (1978:1). After listing a number of the obstructive tactics

²¹ This group was 'formal' to the extent of having a name, contact phone numbers, monthly meetings, and from the beginning of 1981, published a monthly newsletter. It has never become a legal body, such as an incorporated society or a trust.

²² The Plunket Society provided child health services from two weeks post-partum until five years old.

used by hospital and Health Department authorities to limit access to home births, the newsletter concludes:

The number of home births each year in New Zealand is growing, but the future is by no means secure. Events in Australia and in some states of America have demonstrated that a threat exists to the status of domiciliary midwifery, in some instances, to the point of making it illegal. The failure of health authorities to promote domiciliary midwifery may, in the long term, have an effect little different from that of outlawing home births (July, 1978:1).

Two key factors motivated home birth activists in Auckland to enter the public and political arenas to mobilise support for the home birth option. Firstly, the domiciliary midwives' maternity benefit fees were so low that even if a home birth midwife had a full caseload, attending 50 births a year, she earned less than the unemployment benefit and about half of a hospital employed midwife's income (Donley, 1992a:32-35; Health Benefits Review, 1986:55). Thus, few midwives could 'afford' to attend home births. In Auckland, by the late 1970s, the practicing domiciliary midwives could not keep up with the increasing demand for home births (Pauline Ray, *NZ Listener*, 15 March, 1980:22). An additional grievance was the disparity between what the attending doctor and the domiciliary midwife could respectively claim. The midwife was expected to attend a woman throughout her labour and birth and until at least one hour after the placenta was delivered. For this she received \$25. The doctor who only generally came for the birth and third stage could claim \$60 (figures for 1978; in Donley, 1992a:32-35).²³ A second important factor prompting home birth consumers to become organised in Auckland was the countermobilisation effort by key obstetricians connected to the (Auckland) National Women's Hospital. In the late 1970s, leading obstetricians regularly spoke out against

²³ In 1986, midwives could claim a \$75 birthing fee, while doctors could claim \$185 (Health Benefits Review, 1986:133). Doctors claimed the same fee for home and hospital births.

home birth.²⁴ The Auckland Home Birth Association (then called the New Zealand Home Birth Association) was formed by a group of people who wanted to establish an collective political 'voice' to advocate for home birth consumers and midwives (*New Zealand Home Birth Association Newsletter*, July, 1978:2).²⁵

The different orientations of local home birth groups, particularly differences between Christchurch and Auckland, created tensions within the new national home birth association. Home birth association members were divided over whether to prioritise building grass roots networks for a diverse but specific community, or to engage in public and political lobbying. At the 1982 New Zealand Home Birth Association conference in Dunedin, these two divergent forms of collective action were debated through a panel discussion to enable both sides to present their arguments. The conference report in the *New Zealand Home Birth Association National Newsletter* notes that the representative from the Auckland Branch argued that; "we [have] been 'reasonable' long enough, ... we [have] to become more politically aware." The representative from Christchurch contended that home birth "required peace, quiet, unaggressiveness" not "political battles which created anxiety, fear and conflict" (No. 6, 1982:3).

A 'compromise' was reached between these two positions - the New Zealand home birth movement needed both. The report documents that: "Therefore we need two parts to our organisation - those who get on with the job of peaceful birthing and those who fight the political battles to protect what the former were doing" (*New Zealand Home Birth Association*

²⁴ See Appendix III.

²⁵ The New Zealand Home Birth Association decided to collect statistics on home births to be able to demonstrate the safety of this birthing option. A summary of these statistics are presented annually at the home birth conference and published in the home birth association newsletters. This database was analysed by Gulbransen, et al and the results published in the *New Zealand Medical Journal* in 1997.

National Newsletter, No. 6, 1982:3). By the following year, a number of branches had initiated more formal support services which were provided by women for each other. These included antenatal classes, postnatal home help, support groups, birth stories in newsletters and lay birth attendants who assisted at births in conjunction with a domiciliary midwife (*New Zealand Home Birth Association National Newsletter*, September, 1983:8-11). These directed women interested in home birth towards certain kinds of practices, not only for birthing, but also for parenting, such as breastfeeding, bedsharing and non-immunisation. These came out of, and in turn reshaped the available meanings and practices for home birth and parenting.

Mary Bernstein argues that attention needs to be paid to the differences between the collective identity based on mutual recognition among movement participants and the identity "deployed strategically" in public arenas to further movement claims (1997:538). These differences, she argues, can precipitate conflict and ambivalence among movement participants over whether increasing public and political visibility or reclaiming privacy and self-definition offer more promising means to achieve autonomy and control. The public identity articulated by movement leaders, Bernstein suggests, presents a united position that glosses over these 'internal' debates about issues and strategies (1997).

Melucci makes the argument that this tension between creating alternative and submerged cultural spaces or attempting to open up a public space through media and political campaigns is common in movements oriented to prefigurative politics. On the one hand, when movements engage in public conflicts this can reinforce participants' sense of 'belonging' to an identifiable challenging collectivity and can attract new adherents to the movement networks. However, Melucci argues, visible movement actions can also have the perverse effects of provoking countermobilisations,

opening the submerged networks to forms of surveillance and creating conflicts within the network (Melucci, 1985:800-801; 1994:127-128;1995:48). Alternately, some of the movement's cultural innovations may eventually become 'codified' as a part of the cultural resources of civil society, beyond the control of the network participants. In either case, Melucci points out, social movements are caught in a paradox - they need to seek political recognition and to participate in political processes which, at the same time, threaten the autonomy and survival of the submerged network (1989:9; 1994:127-128).

A public voice: Home birth in the media

Melucci argues that the public and political challenges by movement activists depend on the production of alternative cultural codes within the submerged networks. Participants of social movement networks may not necessarily be interested in engaging in public sphere or political debates, preferring instead to focus on exclusive private networks. However, this is not always under the network participants' direct control. Adversaries or bystanders can also raise public debate about a movement and push movement participants to publicly account for their actions (1985:801; 1989:30, 90; 1994:127; see also; Mueller, 1994:235, 255-256).

In the late 1970s and early 1980s, there was a virtual explosion of articles and reports in New Zealand newspapers and magazines relating to home birth.²⁶ Home birth was recast from a private or underground matter into a subject of 'public interest' and conflict. The articles in the mainstream media either presented home birth as a new phenomenon, and were located in the women's or feature pages as human interest stories, or

²⁶ See Appendix III.

articles reported statements made by obstetricians' about home birth. These articles featured in the news pages, and presented home birth as a 'social problem'. The debate over home birth in the media at this time highlights the importance of 'controversy' in attracting media attention.

William Gamson and David Meyer make the argument that we need a complex account of the media to account for the relationships between social movements and the media (1996:285, 287). The media is a site for the reproduction of culture as well as the staging of discursive struggles or "symbolic contests ... among competing sponsors of meaning, including movements" (Gamson and Meyer, 1996:287). Carroll and Ratner suggest that social movements organisations are asymmetrically dependent on the media. Social movements rely heavily on the mass media to relay their messages to wider publics, while the media has a wide spectrum of options for "making the news" (1999:3). Thus, journalists and editors act as gatekeepers for access to the wider public and movement activists need to capture their interest in the context of competition for media attention. Thus the media, McCarthy, Smith and Zald suggest, can be analysed as 'audiences' in themselves (1996:307). They argue that mass media operate as a part of the political opportunity structure. While movement activists can directly lobby politicians and state administrators, the media can critically influence how political elites interpret issues (1996:296-298).

The following are two examples of how those with status and power can define a political debate for a social movement through the mass media. These were the beginning of a series of statements by obstetricians against home birth (see Appendix III). In 1976, the *Auckland Star* ran a story under the headline 'Death and damage - natural birth warning':

Dr Graeme Duncan was speaking at a jubilee course for specialists held to mark the National Women's Hospital's 25th anniversary. "We are now facing a resurgence of

interest in and demand for non-institutional confinements," he said. ..."Certainly current obstetrics had led childbirth to be anything but natural. But if we sacrifice our currently high salvage (of babies) by of abolition some or all of this type of care, are these people prepared to accept the inevitable toll of deaths and damage to their infants?" (*Auckland Star*, 19 July, 1976:16)

Duncan represents home birth as a threat to the baby's safety and thus a matter of public concern. This following excerpt appeared in *The Press*, under the headline 'Home births "almost a form of child abuse"':

New Zealand-born professor of paediatrics, gynaecology and obstetrics in the United States ... Professor S. L. James ... said in an interview in Christchurch yesterday that he was surprised at the numbers of New Zealand parents who were becoming attracted to the idea of home deliveries. ... "Complications cannot be foreseen, and it is of the utmost importance to the mother and the child to have the baby where optimum care can be given. ... To do otherwise is almost a form of child abuse; and to opt out of this responsibility denies the new-born child the right to a full and competitive life after birth" (*The Press*, 14 December, 1977:2).

These releases are indicative of a policy agenda setting exercise aimed at raising public support for more statutory control over home birth. Even though obstetricians had direct access to government policy arenas through the Maternity Services Committee, it still required 'political will' to make changes to the legislation and regulations covering home births.

Interestingly, home birth activists' responses rarely advocated overtly for natural childbirth. This may have been due to a number of factors. Perhaps the media was not interested in 'staging' a debate between expert obstetricians and a group of mothers over whether home birth was safe. Also, perhaps, the 'rules of the game' for petitioning the state favoured framings in terms of 'needs' and 'rights'. Another factor may have been that the diversity of ideas about natural child birth among home birth network

participants led to the construction of a frame that centred on the rights of individual women/ families to determine the kind of birth that they wanted.²⁷ Movement leaders may also have come from feminist or civil liberties advocacy backgrounds, and for them, home birth was more a matter of 'rights' rather than purely a desire for natural childbirth. Out of the intersection of these external and internal tensions and constraints, a collective action frame was developed in which statements about 'injustice', 'agency' and 'identity' were articulated (Gamson, 1992a:7-8).

This collective action frame portrayed the routine use of medicalised childbirth practices and the attitudes of hospital staff as an 'injustice' for which home birth was a solution. This is illustrated in the following two examples. This letter to the editor was written in response to Duncan's 'natural birth warning':

The obstetrical specialists have only themselves to blame if mothers are opting out of institutionalized birth and the routine application of certain medical and surgical procedures What many intelligent women are rejecting is a hospital system that persists in treating them as dim-witted children incapable of making any decisions for themselves (Mary Dobbie, letter to the editor, *Auckland Star*, 3 August, 1976).

A founding member of the Auckland Home Birth Association explains:²⁸

At first, intending to have the baby in hospital, she asked her obstetrician if she could give birth upright, and also if she could be the one to determine whether she needed drugs or

²⁷ In the feature articles that investigated why women were turning to home birth, this diversity is explicit in the constructions of the texts. Women who birth at home give various different reasons for this choice. See; Tully, *Auckland Star*, 7 June, 1976; Scott, *Christchurch Press*, 25 September, 1976; *Central Leader*, 6 March, 1979.

²⁸ The narrative of deciding to birth at home following an experience of being denied the right to bodily self-determination by a doctor appeared in several articles. See; Tully, *Auckland Star*, 7 June, 1976; Scott, *Christchurch Press*, 25 September, 1976; *Central Leader*, 6 March, 1979.

not. Her doctor acceded to the first request but not to the second. "He said that because I was there I would not be able to tell when I needed them, and that the injections needed a period to work." So [Deryn] Cooper and her husband, Geoff Bridgman ... started looking "for a good place to give birth. We heard of a midwife (Donley) and went to see her. Unlike doctors she was keen for us to grill her. She was most forthcoming and seemed to us to have more knowledge" (Ray, *NZ Listener*, 15 March, 1980:22).

In this account, Cooper was interested in birthing upright, a practice associated with 'natural' childbirth, and in being in control of the use of pain relief. The obstetrician was prepared to accommodate her request with respect to the birthing position, but not her desire to be in control of the decision about pain relief. In these two excerpts, the problem with hospital birth is the hierarchical relationship between staff and 'patients'. Dobbie and Cooper both argue that women have the capacity to make decisions about the maternity care they want to receive. And, in denying women's right to bodily self-determination in birthing, doctors and nurses were treating women as 'dim-witted children' rather than 'intelligent adults'.

In the early New Zealand Home Birth Association National Newsletters, and in newspaper and magazine accounts that include a home birth perspective from the late 1970s and early 1980s, the primary frame used by activists promoting home birth centred on women's and/or parents' 'rights' to make informed choices with respect to the birth of their babies. The newspaper article reporting on the formation of the Auckland Home Birth Association states:

The association is not against hospital births. It supports women's right to have their babies where they choose, if the alternative to hospital is safe. "We want home births to be seen as an option and the decision to have a baby at home as a responsible one" (Ann Elder, *Auckland Star*, 16 August,

1978).²⁹

This statement from the home birth association emphasises responsibility and moderation - 'if the alternative to hospital is safe'. The statement indicates the way in which 'women's rights' discourses were being used by home birth activists to connect gendered citizenship to alternative birthing options. The home birth association collective action frame drew on old notions of the rights of citizen mothers,³⁰ and newer frames put forward by radical and liberal feminists. It also reinvested in the latent discourse of the medical profession as 'self-interested' rather than 'humanitarian' to undermine their claims to objectivity in their 'needs interpretation' in relation to childbirth.³¹ This opened possibilities to gather public support to form alliances with elites who may not have cared about home birth, but who were sympathetic towards these aspects of the collective action frame.

The deployment of the 'right to choices for birthing' frame links the home birth movement to the women's health movement. Both movements critiqued the medicalisation of women's health and bodily processes and constructed their position as fighting for women to regain control of their bodies (see for example; Bunkle, 1988; Broom, 1991; Zimmerman, 1987).

Mary Bernstein argues social movements engaging in 'identity' politics tend to construct and deploy either 'inclusive' or 'exclusive' identities. Inclusive

²⁹ For similar comments see also; *New Zealand Home Birth Association National Newsletter*, No. 2, 1980:1; No. 4, 1981:7

³⁰ This frame was used to promote the Midwives Registration Act, 1904 (Donley, 1986:32-33, 39). Women's groups in the 1930s also used it to press their demands for access to pain relief (Donley 1992a:18). See chapter four of this thesis .

³¹ The opposition from doctors' to the registration of midwives in Britain at the end of the last century was framed by many as self-interest, and when this frame won support from politicians, the Midwives Act, 1902 was passed (Donnison, 1977:68-69, 74-87). Those supporting the campaign against maternal mortality conducted by the Health Department in the 1920s also accused resistant doctors of self-interest (Mein Smith, 1986, 28-29).

identities seek to suppress the differences between movement followers and the wider public, while exclusive identities 'celebrate' the difference between those whom the movement represents and 'outsiders' (1997:539-541, 557-560). Home birth activists used an inclusive identity, constructing their position as advocating for the rights of all women to self-determination in childbirth.

There were some articulations which constructed 'women in control of their birthing experience' as improving women's mothering capacities and ability to give birth. Those documented in media texts were more likely to come from health professionals than from consumers. For example, Don Dalley, a Christchurch GP who attended many home births, commented in an article he wrote for the *New Zealand Family Physician* that many people who wanted to birth at home believed that:

Being at home encourages the mother to be "in control". For many women regaining control of their health, and body, from the hospital competitor, adds a personal and emotional dimension to total fulfilment as a mother. Contrary to much medical opinion, these mothers exercise a high degree of responsibility in their attitudes to birth. They are not content to be passive, powerless pawns in the hospital power-game where patients may take little or no personal responsibility (1983:8).

Dalley contrasts responsibility and being 'in control' in childbirth to dependence and passivity and links the former to fulfilling mothering. Donley, a domiciliary midwife from Auckland argued that women being in control of the situation around her assists the progress of her birthing. She is quoted in a newspaper article as saying:

"The difference between a home birth and a hospital birth is amazing. When a woman has her baby at home she is entirely in control; we are guests in her house. Labour is a delicate process and emotional responses are important. If a woman is in her own home and in control of the situation,

she is relaxed and that makes for a far more gentle labour”
(Sigrid Kirk, *Auckland Star*, 24 June, 1981).

It is interesting to note the Donley constitutes domiciliary midwives as ‘guests’. This implies a different position to the ‘expert’ health professional or the ‘health missionary’, the role established for registered domiciliary midwives in the 1900s (Marland, 1997). In this passage ‘home’ is constructed as a place of emotional security and a domain of women’s control (Abel and Kearns, 1991:828).

Politicians and doctors who were antagonistic to home birth attempted to disqualify the home birth rights frame by arguing that home birth was more dangerous than hospital birth for the baby and, thus, women who choose to birth at home were putting their own ‘wishes’ ahead of their babies’ ‘needs’ and ‘rights’ (Donley, 1992a:14-17). The following excerpt from a *New Zealand Women’s Weekly* article, published in 1978 and headlined “Home or hospital birth - the case for both”, provides an excellent example of this counter argument:

“I’ve no doubt about where babies should be born, but I’m biased,” says specialist Colin Mantell, Auckland University Professor of Obstetrics and Gynaecology, smiling in his second floor office in the medical mini-city of National Women’s Hospital, where he is a part-time consultant. “I don’t mind if mothers are delivered at home,” he jokes, “as long as babies are born in hospital. As the child’s advocate, I would say that home deliveries should not be available. I think the time is coming when all babies should be born in big hospitals, not even in small ones” (30 October, 1978:28).

Mantell constructs an image of women who chose home births as mothers who put their babies at risk. The baby is constituted as an individual whose rights, in this case, need to be protected by the medical profession and the state.

There is very little room for compromise or even dialogue between the discourses of the obstetricians who were against home birth and those deployed by home birth activists. In the next chapter I will examine the policy initiatives in the 1980s that sought various means to reconcile this opposition.

Conclusion

Some of the new understandings and practices which were developed within the submerged home birth network have now become part of public discourse. Some have been institutionalised in midwifery education and in hospital midwifery practice. Perhaps the most important innovation is the model which emerged of the 'ideal' relationship between domiciliary midwives and birthing women, and between domiciliary midwives and the home birth associations. This was codified when midwives formed the New Zealand College of Midwives, in 1989.

A question I will explore in more depth in subsequent chapters is: how has the relative 'success' of the home birth movement in achieving more public and political acceptance of home birth affected this grass roots network? I will discuss the responses by home birth association activists to the 'codification' of partnership in following chapters, particularly the sense of 'loss' of the intimate relationships between home birth midwives and birthing women working together in small 'underground' groups. In the last chapter, I will return to this theme in analysing research material from home birth women who have created support groups to support each other in their continued exploration of unconventional mothering practices.

In print media accounts in the late 1970s and early 1980s, including the New

Zealand Home Birth Association newsletters, home birth was promoted by home birth activists as a means for women to be in control of what happens to them during birthing. From the alternative cultural resources developed within the submerged home birth networks, activists publicised the egalitarian reworking of the relationship between birthing women and midwives, rather than the advantages of 'natural birth' at home. Activists made the argument that every birthing woman had a 'right' to control her birthing experience, and with information and support, had the capacity to make the best decisions for herself and her baby. This frame is interesting because it shapes home birth politics in critical ways in the 1990s.

6

Representing home birth: publicity and politics in the 1980s

In hindsight ... home birth ... was something you could actually do. And it's so good for welcoming the baby, and the family, and breastfeeding - so positively, empoweringly combined. It had so much potency because it was a child that had been born at home.

Tilda (Individual interview, Christchurch, 31 May, 1998)

Introduction

The *New Zealand Home Birth Association National Newsletter*, published after the second home birth conference in May 1981, contained the following comments that proclaim home birth as a social movement:

The Home Birth Movement really started in Auckland in 1978, when a group of parents there first formed the NZHBA, after the home birth option had been available there for some time. ... The 9 branches that are now functioning seem to be strong and determined, no matter what the size. Membership in these branches ranges from 10 (Taranaki) to 200 (Auckland) and totalled 414 last May (No. 4, 1981:1).

The total number of domiciliary midwives now practising in NZ totals 18, with half of these working in the Auckland area.

... Between May 1980 and May 1981, 350 babies were born at home; more than half of these in the Auckland area. The total number of babies born at home in NZ over the past 6 years has exceeded 1,000. These figures show that home birth in NZ is not just a passing fad - it is a very real social change that is here to stay (No. 4, 1981:2).

The conference closed at 3 pm with participants feeling they had achieved something worthwhile. The sharing of ideas, jokes, and news was conducive to a feeling of solidarity - a feeling that the home birth movement is alive and kicking (No. 4, 1981:4).

These excerpts indicate the emergence of a movement identity among activists from the New Zealand Home Birth Association. The Wellington Branch writers who produced this newsletter deploy a representational language that is associated with movements. This, Charles Tilly argues embraces claims of being “worthy, unified, numerous and committed” (1998:467-469). In naming themselves as the voice of a movement, they were signalling to opponents, allies, politicians, the public and to other home birth association members that their challenges needed to be taken seriously.

In this chapter I provide an account of home birth activism in the 1980s that examines the ways in which movement activists entered into political policy debates. I argue that the skills activists acquired in these first engagements led to aspirations to seek changes that would favour home birth. To do this, activists made strategic assessments of the political opportunity structure and framed their demands in ways that could be realised through policy formulation.

This first round of political contestation had other consequences as well. It produced irreconcilable rifts within the New Zealand Home Birth Association and between some midwives and the New Zealand Nurses' Association. Consumer support for domiciliary midwives provided an

important impetus for the formation of the New Zealand College of Midwives. However, I argue that attention also needs to be paid to changes in the political opportunity structure with a move to more consumer friendly health services. This made consumer support a key asset for midwives seeking government recognition for the College as the representative of midwifery interests.

'Mother and Baby at Home - The Early Days'

In 1980, leading obstetricians and nurses decided to take action against the growing interest in home birth. Through the maternity services committee of the Board of Health an inquiry into 'home confinements' in New Zealand was initiated. The report, entitled *Mother and Baby at Home - The Early Days*, was drafted in 1982 and released in February, 1983 (Donley, 1992a:16).¹ To ensure the safety of home birth, the report advocated, obstetricians needed to be able to exercise more control over domiciliary midwives and the GPs who attended home births. The Minister of Health and the Director-General of Health had the power to implement the recommendations of the Maternity Services Committee report as 'obstetric regulations' without going through a parliamentary process (Donley, 1992a:16; Maternity Services Committee, 1982:9).

The recommendations contained in *Mother and Baby at Home* included the following: domiciliary midwifery contracts should only be issued to registered midwives who were also registered nurses with "recent experience in a modern obstetric unit", and who attended annual two week refresher courses at a high technology base hospital. Furthermore, the

¹ The home birth association received a leaked draft before the final version was released, which they distributed and commented on.

report advised that domiciliary midwives should be contracted to Hospital Boards, instead of to the Department of Health, work out of obstetric units and be reviewed by the Obstetrics Standards Review Committees (Maternity Services Committee, 1982:5-8). GPs attending home births were also targeted by the Maternity Services Committee. It recommended that GPs who accepted home birth clients should have a hospital maternity contract, they should apply strict criteria to determine which women could birth at home and that they should actually attend the birth (1982:42-47).²

Aussie Malcolm, the Minister of Health in the early 1980s, was a vocal critic of home births. In the *Parents Centre Bulletin*, he argues that:

"Giving birth is a natural process but for the child it is also the most dangerous time of his or her life. Recognition of that fact has led modern obstetrics to go to great lengths to ensure that birth is a safe process for baby. ... As doctors and hospitals become more enthusiastic about what could be achieved, some mothers started saying "it may be much safer for baby, but it's not much fun for me." It is out of this attitude that much of the enthusiasm for the homebirth movement in New Zealand has grown" (9 February, 1984:9).

In his view, more medical control over home birth services signified improved safety (*New Zealand Herald*, 2 February, 1983). Other commentators saw the report as striking a reasonable compromise between two very opposed sides. For example, the *Auckland Star* carried an editorial which described the recommendations in the report as follows:

While the Maternity Services Committee is opposed to home births, it has had the good sense to acknowledge that they

² Appended to the report was a 'risk list', or indications for referral to an obstetric specialist. Items on the list home birth activists particularly objected to were that women over thirty with their first pregnancy, or women with more than two previous abortions should have an antenatal consultation with an obstetrician. Also the list specified that women should be transferred to the care of an obstetrician after twelve hours first stage labour and one hour second stage labour (1982:42-44).

will continue and wisely has recommended ways to reduce the risks to both mother and baby (*Auckland Star*, 2 February, 1983).

The leadership of the New Zealand Home Birth Association, both nationally and in the branches, viewed the Maternity Services Committee's report as a significant threat to home birth services. Activists objected to all of these recommendations, fearing that they would restrict many women from being able to access a home birth. Also, it seemed unlikely that domiciliary midwives would continue to practice under such conditions (*New Zealand Home Birth Association National Newsletter*, No. 8, 1983:6-9). In a press release, a spokesperson for the New Zealand Home Birth Association stated that the recommendations "threatened their [domiciliary midwives'] autonomy and the special nature of home births" and the "right of every New Zealand woman who wants a home birth to have one" (*The Press*, 2 February, 1983).³

To engage in effective lobbying, participants in the New Zealand Home Birth Association had to make collective assessments of the 'political opportunity structure' (see for example; McAdam, 1994:36; Skocpol, 1992:41-60; Tarrow, 1994:82).⁴ The tactics and resources available to home birth activists were limited. The New Zealand Home Birth Association had a membership of about 500 people spread around the country (*New Zealand Home Birth Associations National Newsletter*, No. 4, 1981:1). Home birth association activists decided to concentrate on lobbying Members of Parliament directly, but they also publicised their views through the media (*New Zealand Home Birth Associations National Newsletter*, May, 1983:6; see also appendix two).

³ This was also published in the *New Zealand Herald* and the *Auckland Star* on 2 February, 1983. For a list of newspaper articles relating to the Maternity Committee report and the Nurses Amendment Act, 1983, see appendix three.

⁴ See chapter three for an outline of some of the debates among social movement theorists in relation to this concept.

Before the report was released, the Auckland Branch succeeded in having nationwide media coverage of a press release warning that some women who could not access professional care were choosing illegal unattended home births, that is, births without a doctor or a midwife present:⁵

Some women are delivering their own babies at home because the Health Department has forced qualified domiciliary midwives out of business ... [as] home birth midwives earned a maximum of \$8000 a year (*Auckland Star*, 24 October, 1982).⁶

The New Zealand Home Birth Association did not publicly support unattended home births or lay midwifery, although there was dissension about this amongst association members (*New Zealand Home Birth Associations National Newsletter*, September, 1983:3). This press release was intended to signal state administrators that women would continue to birth at home even if regulations were more stringent, as well as to press their claims for an increase in the domiciliary midwives maternity benefit.⁷ Whereas the home birth groups in Australia and North America often worked/ work closely with lay midwives (Abel and Kearns 1991:826; DeVries, 1985; Noble, 1997; Sullivan and Weitz, 1988), the New Zealand Home Birth Association used the possibility of lay midwives as leverage to extract more governmental support for registered home birth midwives.

After the publication of the *Mother and Baby at Home* report, home birth activists sought to publicly reframe the recommendations as a bid by obstetricians and nursing leaders to control home birth. Activists argued

⁵ Lobbying the Maternity Services Committee began with submissions to their inquiry into home birth. In October, 1982, the Auckland Home Birth Association received a leaked copy of the draft report and they responded with another submission which was sent to every Member of Parliament (Donley, 1992a:15-16; *New Zealand Home Birth Association National Newsletter*, No. 7, 1982:6-7).

⁶ This article was also published in the *Christchurch Press*, 26 October, 1982:6 and the *New Zealand Herald*, 25 October, 1982.

⁷ Personal communication, Joan Donley, 15 June, 1997.

that the Maternity Services Committee was motivated by self-interest, rather than the interests of babies as they claimed. Donley, for instance wrote in a letter to the editor of the *Auckland Star*, in response to the editorial quoted above:

... the real issues involved in the debate over home birth ... is a power struggle between obstetricians-hospital boards ... and women who are trying to regain control over their bodies (16 February, 1983).

Another home birth supporter wrote:

I feel shocked that in a "free" country a small officially selected group of professionals can develop restrictive guidelines and use the power of the state to impose them on unwilling citizens (Marin Adams, 11 February, 1983).

For home birth activists 'home birth' was not just a site for childbirth. It was a site where women/ families and their birth attendants, rather than obstetricians, had control. Home birth activists interviewed for this research continue to define home birth in this way, and to try to 'protect' home birth from forms of surveillance by hospital based providers.⁸ This no longer requires regulation. The health restructuring has opened opportunities for hospitals to gain contracts with funding authorities to offer home birth services.

The New Zealand Home Birth Association distributed information about the report around the country, urging branch associations and home birth supporters to write letters to the politicians, meet with their local Hospital Boards and Members of Parliament, and hold public meetings to discuss

⁸ Research done in New Zealand in the early 1990s found that the desire to be in 'control' was the main reason women gave for choosing a home birth (Abel and Kearns, 1991; Fersterer, 1993, Jakobsen, 1991). A large study in the North of England also found that being in control was the most commonly cited advantage of home birth for the women they interviewed (Ackermann-Liebrich U, Voegli T, Guenther-Witt K, Kunz I, Zullig M, Schindler C, et al, 1996).

the report.⁹ The newsletters told home birth supporters to "remind" politicians of the government's responsibility to take an "impartial position", and its "obligation to fund the services consumers wanted". To counter the "misinformation" circulated by obstetricians, home birth supporters were asked to inform politicians of the "facts" by using the statistics collected on home births by the New Zealand Home Birth Association that demonstrated the safety of the home birth services (*New Zealand Home Birth Association National Newsletter*, May, 1983:5).

At both the national and at the branch level, association committees made personal contact with Members of Parliament. They sought allies amongst those who were already critical of the medical profession, hospital boards and the government's health policies. Fran Wilde, Labour MP for Wellington Central, for instance, told a public meeting organised by the Wellington Branch of the Home Birth Association that the medical profession used their "claim to superiority to protect their own power, status and economic interest" (*New Zealand Home Birth Association National Newsletter*, No 8, 1983:2-3).¹⁰ Michael Cullen, Labour MP, addressing the 1982 New Zealand Home Birth Association conference, argued that there was a rising impatience with a welfare state founded on "social ideologies which call for uniformity and a single set of attitudes

⁹ *New Zealand Home Birth Association National Newsletter*, each issue from No. 6, (July) 1982, to November, 1983, includes articles on the Maternity Services Committee report, submissions from home birth association branches, reports of home birth associations' meetings with hospital boards, politicians and the New Zealand Nurses' Association. Two extra editions of the newsletter were put out to keep branches informed. See also *Christchurch Home Birth Support Group Newsletter*, Vol. 2 No. 5, 1982, p. 1; Vol. 3 No. 2, 1983:2; Vol. 3, No. 2, 1983:2, containing information and urging people to write individual submissions.

¹⁰ This comment was made at a public meeting organised by the Wellington Branch of the New Zealand Home Birth Association, October, 23, 1982. At other home birth meetings Michael Cullen (Donley, 1992:15; *New Zealand Home Birth Association National Newsletter*, No. 7, 1982:2) and Ann Hercus expressed similar views (*Christchurch Home Birth Support Group Newsletter*, Vol. 3, No. 11, 1983:7-8).

which attempt to eliminate any deviation" (*New Zealand Home Birth Association National Newsletter*, No. 6, 1983:2-3). He also criticised the disproportionate government funding for hospital, high technology services at the expense of primary care.

The home birth associations were strongly opposed to domiciliary midwives being contracted through hospital boards, or in any way under the jurisdiction of hospital based authorities. With no requirement to supply a home birth service, they feared that some Hospital Boards would not provide one.¹¹ Grace Neill in 1904, and Tom Paget and Henry Jellet in the 1920s and 1930s had believed that it was preferable for midwives to be contracted with the Health Department rather than local hospital boards (Donley, 1986:33; Mein Smith, 1986:48). They, like home birth activists in the 1980s, viewed hospital boards as dominated by doctors and inclined toward protecting their professional interests. In contrast to Paget and Jellet who wanted to maximise their opportunities for surveillance over midwives, home birth activists saw the contract with the Health Department as offering midwives - and consumers - more autonomy than a contract with a hospital board who could directly supervise the midwife's practice. In their contribution to *Women Together, A History of Women's Organisation in New Zealand, Ngā Rōpu Wāhine o te Motu*, Donley and Brenda Hinton comment that:

Because [domiciliary contracts] were with the Department of Health, rather than local hospital boards, the midwives and women they attended were outside the control of their local obstetric bureaucracies. This independence was a key factor

¹¹ The Thames Hospital Board's obstetric advisor had already announced his intention to prevent domiciliary midwives and general practitioners from attending home births, and the North Canterbury Hospital Board stated it would not provide refresher courses for domiciliary midwives (*New Zealand Home Birth Association National Newsletter*, No. 8, 1983:7-8, 15). If the Maternity Services Committee's recommendations had been implemented, this would have eliminated the option for legal home births in these areas.

in the survival of the home birth option in New Zealand (1993:278-279).

Furthermore, home birth activists argued that hospital boards ran hospitals, and hence their focus was on pathology and sickness and not community based *health* projects (*New Zealand Home Birth Association National Newsletter*, No. 8:8, 15). Interestingly, the home birth association members at the May 1983 conference decided they would reconsider this position if the proposed area health boards - with greater emphasis on consumer/ community participation and primary care - were established (*New Zealand Home Birth Association National Newsletter* May, 1983:14; November, 1983:1). Home birth activists were not just contesting increased state sanctioned regulation and surveillance of home birth, but also ensuring the continuation of a preferable political opportunity structure.

These strategies illustrate complexity and ambivalence in home birth activists' interactions with the state. The state could be a coercive agent for medical/ nursing interests or an agent protecting women's rights of choice for childbirth. A few home birth activists advocated a complete 'exit' from the state funded health system through private midwifery, which had been established in Australia and the United States. This, they argued, would avoid the forms of control the Health Department could exercise through the domiciliary midwives maternity benefit over midwives and women intending to birth at home.¹² However, most home birth activists supported the arguments that all birthing women had a right to "good, free maternity care" (funded through taxation) and that a private midwifery service would be elitist (*New Zealand Home Birth Association National Newsletter*, Vol. 7, No. 5, 1983:15). Furthermore, such schemes could undercut the political efforts aimed at achieving more equitable funding for home birth.

¹² See; *New Zealand Home Birth Association National Newsletter*, Vol. 7, No. 5, 1983:15; No. 8, 1983:10-11; May, 1983:13; *New Zealand Home Birth Associations National Newsletter*, July, 1985:13.

The Home Birth Association activists envisaged another potential role for the state - to make resources available to enable people to take responsibility for their own health. This is summed up in a letter from the Wellington Home Birth Association to the new Minister of Health in 1985:

Home birth parents over the past six years have shown a great capacity for mutual help and support as branches of the Home Birth Association throughout the country have run their own antenatal classes, educational seminars and postnatal support groups. This is an excellent example of people helping themselves. However, an efficient government sponsored domiciliary midwifery service is needed to enable this self-help process to continue - because in the end it all depends on the availability of domiciliary midwives (*New Zealand Home Birth Associations National Newsletter*, Vol. 2, No. 5, 1985:15).

Save the midwives

Most of the recommendations of the Maternity Services Committee report were never implemented. The recommendation, however, that domiciliary midwives must be registered general and obstetric nurses or registered comprehensive nurses was drafted into the Nurses Amendment Bill, tabled in September, 1983 (*New Zealand Home Birth Association National Newsletter*, No. 8, 1983, pp. 2-4). This meant that midwives without nursing training, that is, direct entry midwives, would no longer legally be able to practice domiciliary midwifery. A further clause in the Nurses Amendment Bill gave Medical Officers of Health the power to suspend a domiciliary midwife suspected of practising in an unhygienic manner. The bill also specified that nurses had to undertake technical institute training to become midwives (through the Advanced Diploma of Nursing with a midwifery option). All these clauses were supported by the Nursing Council and by the New Zealand Nurses' Association, despite strong protests from some

members of the Midwives Section of the New Zealand Nurses' Association. The Nurses Amendment Bill was referred to a Select Committee and the New Zealand Home Birth Association and various branches prepared submissions. Donley quotes Michael Basset, a member of the Select Committee, commenting that "as a very small minority group, the New Zealand Home Birth Association had done some very effective lobbying" (1992a:25).

The Home Birth Associations were concerned that there was already a shortage of midwives in New Zealand, particularly domiciliary midwives. As the education outlined in the Nurses Amendment Bill required for registration took six years, this would increase the shortage of midwives. This included four years of course work and two years on staff at an obstetric unit. In the course work, only a couple of months of the Advanced Diploma of Nursing (midwifery option) were devoted to clinical midwifery (Donley, 1986:101-109; Papps and Olssen, 1997:126). Also direct entry midwives trained overseas would no longer be able to obtain midwifery registration in New Zealand (*Save the Midwives Newsletter*, No. 1, 1983:2, 4-9). Home birth activists argued that the Nursing Council and the New Zealand Nurses' Association's intention in the Bill was to assimilate midwives into nursing (*New Zealand Home Birth Association National Newsletter*, November, 1983:2-3). Instead, it drew the attention of consumers and midwives outside of the home birth networks to the issues surrounding midwifery education and registration and prompted a counter mobilisation (Donley, 1992a:25).

Some members of the Auckland Branch of the New Zealand Home Birth Association, in conjunction with concerned midwives and other consumers formed a pressure group called 'Save the Midwives' to concentrate on fighting the Nurses Amendment Bill, 1983, and ensuring the future survival

of midwifery.¹³ The Save the Midwives activists deployed the 'rights to birthing choices' rhetoric to reframe the Nurses Amendment Bill, 1983, as an attack on parents' rights to make birthing choices, as well as an attack on domiciliary midwives. This is summed up on the inside cover of the first newsletter printed by Save the Midwives:

The women who began "Save the Midwives" see their rights as consumers being eroded by the Nurses Amendment Bill; their right to a particular choice of birth attendant is removed and their responsibility for their infant is usurped by the Bill which makes provision under law for the State to restrict the range of birth attendants available, thus implying the inability of parents to make safe choices for their baby's care. We also see the profession of midwifery is being seriously downgraded by this Bill; in fact the provisions introduced in the Nurses Amendment Bill spell the beginning of the end for midwifery in New Zealand (*Save the Midwives Newsletter*, No. 1, 1983:1).

The Nurses Amendment Act was passed with minor modifications and became effective 1 April 1984. Two direct entry midwives were working in domiciliary practice when the Act was passed. They were covered by a 'grandfather clause' which enabled them to continue attending home births (Donley, 1992a:24, 26). One consequence of the political mobilisation against the Maternity Services Committee report and the Nurses Amendment Act, 1983, was that activists developed knowledge of the political system, effective lobbying tactics and personal contacts in the government.

Over the next years, utilising the skills they had developed in the intensive engagement with the state in 1983, home birth activists took the initiative in calling for policy changes with respect to home birth. This included the

¹³ See for example; "Save the Midwives" Association Press Release, 13 September, 1983; Donley, 1992a:25; *New Zealand Home Birth Association National Newsletter*, May, 1983:10; November, 1983:4

continued lobbying for increases in the domiciliary midwives benefit and home help following a home birth as well as new demands for changes in legislation to reintroduce direct entry midwifery educational programmes and midwifery autonomy. Underpinning these claims was another claim for more consultative and participatory policy decision making processes which included consumer representation. However, it took another six years before the home birth issues relating to midwifery autonomy and direct entry midwifery courses would be addressed in government policies.

The minimal change which eventuated from the amendment to the Nurses Act, 1983, as compared to the extent of the regulation proposed in the Maternity Services Committee Report (1982) could be interpreted as 'a success'. This gave home birth activists a sense that political opportunities existed to justify continued collective action - that further gains were possible (Gamson and Meyer, 1996:286). This prompted some activists to press for changes to the regulation of midwifery and more inclusive policy making processes with respect to consumers of maternity services.

Changing organisational structures

The debates around the *Mother and Baby at Home* report had other significant consequences, both for the New Zealand Home Birth Association and for the Midwives Section of the New Zealand Nurses' Association. One of the greatest issues for the home birth associations and for domiciliary midwives was the role of the New Zealand Nurses' Association in drafting the Maternity Services Committee report. Most of the recommendations cited above were initially proposed by the New Zealand Nurses' Association (*New Zealand Home Birth Association National Newsletter*, No. 6, 1982:8). The Nurses' Association was the professional

body to which domiciliary midwives belonged. This was to have major repercussions, eventually leading to midwives breaking away from the New Zealand Nurses' Association and setting up a separate New Zealand College of Midwives. Ironically, conflicts between the New Zealand Home Birth Association national executive and the Auckland Branch over which strategy to take in dealing with the New Zealand Nurses' Association would also contribute to the dissolution of the New Zealand Home Birth Association as a national body (Donley, 1992a:15-16; *New Zealand Home Birth Association National Newsletter*, No. 8, 1983:13-14).

The New Zealand Home Birth Association was based on a traditional hierarchical structure with a constitution which included formal rules for meetings. It was directed by a National Executive comprised of the secretary from each branch association and three national office holders. Initially the idea was that the national office would be rotated around the branches, to encourage greater participation. The branch hosting the conference would form the national office (*New Zealand Home Birth Association National Newsletter*, No. 6, 1981:4). However, at the 1982 conference the three office holders of the national executive were split first between Wellington and Dunedin, and in the following year, between Wellington, Christchurch and Tauranga. The Auckland Home Birth Association had a large influence in the New Zealand Home Birth Association through having the biggest share of the votes at conferences and regional meetings, and through editing the national newsletter.¹⁴

During the time the home birth associations were engaged in lobbying against the Maternity Services Committee and fighting the Nurses Amendment Act, the differences in political orientations between the

¹⁴ Except in from May, 1981 - May, 1983, and from 1990 - 1992, when Wellington Home Birth Association took responsibility for publishing the national newsletter.

various groups within the New Zealand Home Birth Association started to become problematic. Donley notes the conflict occurred primarily between the Auckland Home Birth Association committee members and the National Executive over their relations with the New Zealand Nurses' Association (Donley, 1992a:15-16). The Auckland Branch of the Home Birth Association wrote a "scathing analysis" in response to a leaked draft of the *Mother and Baby at Home* report (Donley, 1992a:15-16). They argued that the New Zealand Nurses' Association was trying to undermine midwifery and, citing the World Health Organization, 1972, definition of a midwife, insisted that midwives were not nurses.¹⁵ This was sent to the national executive to be distributed to the branches for discussion. It was never sent out and some months later the Auckland Branch took the initiative and not only sent this submission to the Maternity Services Committee but also to every Member of Parliament (Donley, 1992a:16; *New Zealand Home Birth Associations National Newsletter*, No. 7, 1982:6-7).

The New Zealand Nurses' Association National Executive received a copy of the submission from a Member of Parliament and they "complained bitterly" to the New Zealand Home Birth Association national executive. They argued that they were not against home birth and were interested in "useful dialogue". In response, the national executive of the New Zealand Home Birth Association decided to try to "improve relations between the two organisations" and "undo the damage done" by Auckland's more

¹⁵ This definition is as follows: A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/ or legally licensed to practice midwifery. The midwife is able to give the necessary supervision, care and advice to women prior to and during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the woman, the newborn and the infant. (New Zealand Nurses' Association, 1989:7). The critical words in this definition are that a midwife *is a person*, not a 'nurse', and 'a midwife is able ... to conduct deliveries on her own responsibility', not under the supervision of a medical practitioner.

radical stance. They apologised "on behalf of the persons or branch concerned" to the Nurses' Association (Donley, 1992a:16; *New Zealand Home Birth Association National Newsletter*, No. 8, 1983:13-14).

This raised questions about who was authorised to speak for the home birth movement and how much local autonomy could be acceded to branch associations. It also created debates about whether "radical" or "respectable" and "unemotional" strategies were more cogent in mobilising support for the home birth movement (*New Zealand Home Birth Association National Newsletter*, September, 1983:4). These conflicts were expressed in disputes over the structure and constitution of the New Zealand Home Birth Association. At the third home birth conference in Wellington, Auckland Home Birth Association representatives raised their dissatisfaction with the structure of the New Zealand Home Birth Association. As they explain in the national newsletter:

Admittedly Auckland is responsible for this traditional hierarchical structure [of the New Zealand Home Birth Association]. ... Auckland held the first national conference to form a national organisation, 1980. In setting up the legally required constitution we acted on the basis of underlying, mainly unconscious, attitudes and routines. So we had the pyramid structure with the president and secretary at the top of a decision making (power) hierarchy. ... Hierarchical structures have been called 'patriarchal'. In a male dominated society, male ways of doing things (like meetings and organisational structures) have become the norm. Now that women are becoming more politically involved, more democratic, consensus structures are developing in such areas as feminist, peace, conservation organisations - where ever women are in large numbers (*New Zealand Home Birth Association National Newsletter*, September, 1983:1-2).

The Auckland Home Birth Association argued that the hierarchical structure of the New Zealand Home Birth Association had led to the 'grassroots' or the local branches becoming passive and dependent on the National

Executive. They wanted each local association to work autonomously, backed up by good networking. "To build a strong national organisation," Auckland contended, "we need a strong network, not a strong executive" (*New Zealand Home Birth Association National Newsletter*, September, 1983:2). This was also seen as consistent with the philosophy of home birth, which Auckland members argued, was a commitment to women/ families taking responsibility and making decisions through discussion and consensus (*New Zealand Home Birth Association National Newsletter*, September, 1983:2).

At the next home birth conference in Christchurch, The Auckland Home Birth Association put forward a remit which read: "That the New Zealand Home Birth Association Incorporated be wound up as from the 6th day of May 1984 and that any funds and property be distributed among the branches equally and that notice of this resolution be given to the registrar" (*New Zealand Home Birth Associations National Newsletter*, Vol. 2, No. 2, 1984:15-17). The remit was lost. The Auckland Home Birth Association decided to opt out of the New Zealand Home Birth Association. The national newsletter collective, who were members of the Auckland Home Birth Association, continued publishing the newsletter which gave the former Auckland Branch a continuing voice in home birth association debates.

Before the conference in Nelson in 1985, there had been discussions in most areas about what was wanted for the national structure. Some areas prepared discussion papers which they sent out to the other branches.¹⁶ Waikato, Dunedin and Tauranga branches of the Home Birth Association

¹⁶ *New Zealand Home Birth Associations National Newsletter*, Vol. 2, No. 5, 1985 includes papers from Nelson, Christchurch, Auckland Home Birth Associations, the national president and the national treasurer. Some of these are also in the Christchurch Home Birth Association archives.

argued that an incorporated national structure was important in the face of nationally organised opposition from the Obstetricians and Gynaecologists Society and New Zealand Nurses' Association. Also, because "many issues of importance are dictated to us by the state" there needed to be a national spokesperson and a national structure.¹⁷ Christchurch and Wellington Home Birth Associations' members decided to support Auckland's position.

At the conference, it was decided to wind up the incorporated structure of the New Zealand Home Birth Association.¹⁸ This was replaced by a loose 'network' of individual local associations. Representatives for home birth associations would meet at annual conferences and regional meetings where issues relating to home birth nationally and locally would be discussed. The Wellington Home Birth Association agreed to take responsibility for political lobbying of central government arenas and the Auckland Home Birth Association continued to produce the national newsletter. Although there must have been some disappointment, the conference reports indicate a sense of relief and excitement about the change (*New Zealand Home Birth Associations National Newsletter*, No. 28, 1985:1-8). Employing a birthing metaphor, Donley called this three year struggle over organisational form: "hard labour, painful transition, gentle birth" (1992a:20).

The new committee structure, sometimes also called 'core group', adopted by most home birth associations was an open collective, where anyone who was interested could contribute. Decision making was, and continues to be through consensus. The local focus helped sustain close ties to domiciliary midwives. This helped to keep the movement active. The loose

¹⁷ *New Zealand Home Birth Associations National Newsletter*, Vol. 2, No. 5, 1985:4, from the Nelson Home Birth Association.

¹⁸ The structure of this alternative organisation was never decided on and was later abandoned.

identity of the 'Home Birth Associations of New Zealand' could be invoked for statistics collection, a national newsletter (which has not been published since the end of 1998) and annual conferences. This was changed to the 'Home Birth Associations of Aotearoa/ New Zealand' in 1989 following initiatives aimed at making home birth associations more aware of the issue of 'biculturalism' (*Home Birth Newsletter*, No. 42, 1989). However, these names for the home birth associations' collective are flexible, particularly as they are not often used.

The professionalisation of midwifery

The New Zealand College of Midwives was formed at the conference of the Midwives Section of the New Zealand Nurses' Association in Auckland in August, 1988. The delegates decided to "disband" the Midwives Section because many midwives perceived the Nurses Association as "undermining" midwifery (New Zealand Nurses' Association, 1989:6, 13). Membership to the New Zealand College of Midwives was also open to the consumers and consumer groups who had publicly and politically promoted midwifery in the 1980s.¹⁹

How did this new collective identity of midwifery emerge? Many activists associated with the formation of the New Zealand College of Midwives, midwives and consumers alike, agree that the catalyst prompting the reconstruction of a midwifery identity was the support for a certain kind of 'midwife' from consumer networks of the home birth movement, Save the Midwives and other maternity action groups. Karen Guilliland, national director of the New Zealand College of Midwives, in her opening address

¹⁹ A consumer is defined as someone who is not a registered health professional (*New Zealand College of Midwives Constitution*, 1989).

to the 1990 conference of the College told participants that:

Under the medicalised maternity service of the last 40 to 50 years, we forgot the individual patient. While we were studiously caring for the special features of the disease, that is in this instance, pregnancy and childbirth, we forgot that a well woman is the expert on herself. As nurses, we asked the Doctor what they wanted instead. It was the women themselves who started questioning this approach and thankfully some midwives were listening. This questioning of the status quo was really the beginning of this College (1990:1-2).

It is interesting how Guilliland calls medically oriented midwives 'nurses', thus redefining 'midwives' as those practitioners who are woman focussed. Joan Donley similarly argues that:

Today, New Zealand midwives stand in a favoured position - nationally and internationally. Nationally, we have legal equity with the doctors; internationally, we are in the vanguard, having begun a movement to make changes to the ICM constitution to accommodate consumers - women and midwives in partnership.^[20] I have no hesitation in claiming that these changes have come about because a so-called 'vociferous minority' - the NZ Home Birth Association and a handful of domiciliary midwives - challenged a well-entrenched group which was well on the road to establishing monopoly control of maternity services (Donley, 1992b:31).

Judi Strid, a consumer who came from the New Zealand Home Birth Association and was a founding member of Save the Midwives also told the New Zealand College of Midwives conference that:

The successful passage of the Nurses Amendment Bill in 1990 was due to the joint action of women and midwives working together. Women got behind the midwifery cause because we believed in what midwifery had to offer (1994:97).

²⁰ The ICM is the International Confederation of Midwives.

At the beginning of the 1980s, however, the New Zealand Nurses' Association and, Donley asserts, most hospital employed midwives were more likely to view domiciliary midwives and their consumer supporters as a threat to the professional status of midwifery rather than as potential role models (1986:105). This raises the question of how, between the beginning and the end of this decade, 'consumer support' came to be reconstituted by midwives outside the home birth networks and by key policy makers as an advantage and a resource? A more complex analysis of this shift needs to take account of the historical interrelations between various maternity service providers and wider changes in the health sector which were occurring at the time. We need to ask the question of how consumer support became reconstituted as a resource. to examine how it works and does not work , in the 1990s.

In chapter four I argued that the relationships between various sets of doctors, midwives and nurses has historically been characterised by shifting accommodations between rivalry and interdependence. With the advent of welfare state funded maternity care for women in 1939, the interprofessional competition was to some extent 'resolved' by giving GPs the responsibility to provide antenatal and birth care, while most midwives only provided the intrapartum care of labour support and immediate postpartum care for birthing women (Mein Smith, 1986:47). Increasingly, GPs became dependent on midwives to provide these services. As obstetricians consolidated their specialised area of professional jurisdiction, GPs lost the skills to deal with birthing complications (Donley, 1986:50-51, 115). Obstetricians, however, also rely on midwives to provide intrapartum care. Therefore, midwives' skills were increased relative to GPs. The demands from consumers of maternity services in the 1980s for midwifery care came at a time when older rivalries between doctors and midwives were resurfacing.

At the same time, the New Zealand Nurses' Association and the Nursing Council made midwifery a post-graduate nursing qualification (Donley, 1986:101-103; Papps and Olssen, 1997:126). Some midwifery leaders within the New Zealand Nurses' Association hierarchy were critical of this educational programme because the education was insufficient to enable New Zealand graduates to practice as midwives in the United Kingdom and Europe. Many New Zealand nurses went to the United Kingdom or Australia to attain midwifery qualifications, rather than train through the Advanced Diploma offered at New Zealand Technical Institutes. Donley notes that 117 of the 144 midwives who gained registration in 1984 had completed their midwifery education overseas (1986:104). Midwives in these countries had separate professional organisations to nurses (Donley, 1986:103). An unintended consequence for the New Zealand Nurses' Association of their midwifery education policy was that it brought midwives into New Zealand who had been exposed to midwifery as a separate profession from nursing.

The restructuring of the health system into area health boards, I would argue, was an important factor in reconstructing consumer support and participation in decision making as a 'resource' rather than a threat to professionalism. The establishment of area health boards created a political opportunity structure that was more conducive for the inclusion of consumer voices in health policy making. This followed a number of earlier government initiatives that signalled a more participatory democratic approach to policy making. In 1984, the government established a Ministry of Women's Affairs. The new ministry set its policy agendas through holding 'women's forums' around New Zealand. These offered opportunities for home birth activists to promote their cause. Home birth was included as a policy priority (Ministry of Women's Affairs, 1985:51). Home birth activists also made submissions to the 1986 Health Benefits Review, who noted that:

... there is now a vocal home birth movement that has spoken out for the midwives: the number of submissions we have received in support of them bears witness to this (1986:56)

This was followed by another round of home birth association submissions to the Royal Commission on Social Policy (1988) where activists again lobbied for direct entry midwifery courses, midwifery autonomy and more support from the Health Department for home births.²¹ The Report of the Cervical Cancer Inquiry (1988) underscored the degree to which obstetricians and gynaecologists placed their professional interests ahead of those of their patients (Coney, 1988). Judge Silvia Cartwright recommended major changes to the delivery of medical services, including the establishment of a health commissioner to protect the right of patients to make informed decisions with respect to their health care (Coney, 1994c:23-24).

The area health board system was a compromise between economic rationalism and local consumer participatory decision making (Ashton, 1992:150; Cheyne, O'Brien and Belgrave, 1997:223-226). The Area Health Board Act was passed in 1983 and enabled hospital boards to amalgamate with the local branch of the health department to integrate some primary health services and hospital services. In 1988, the government reorganised the hospital boards into fourteen area health boards across New Zealand. The area health boards were contracted by the Minister of Health to be responsible for health promotion and protection as well as hospital treatment services in the areas under their jurisdiction (Cheyne, O'Brien and Belgrave, 1997:223-226). It was envisaged that primary health care would eventually be transferred to the area health boards and the boards were required to look at ways of coordinating community, primary and

²¹ Submission included in *Home Birth Newsletter*, No. 37 (1978:19), *Christchurch Home Birth Association Newsletter*, Vol. 7, No. 7, (1987:11-12).

secondary health services (Caygill, 1988:18).

The Health Department took on the role of a policy and funding unit who developed and monitored the contracts between area health boards and the Minister of Health. Each area health board was comprised of a locally elected board and, following the State Sector Act, 1988, a management structure headed by a general manager. Area health boards were required to set up service advisory groups for specific areas of health care and community health committees to advise the board on the health service needs of the communities they represented. These were made up of consumer representatives and health professionals and provided avenues for people to have input into the planning of health services in their region (Martin, 1992:22). Through decentralisation, a new management structure and a range of forums for community consultation, it was hoped that health services would become more efficient, accountable and responsive to their local communities (Royal Commission on Social Policy, Vol IV, 1988:56 57).

It was the rhetoric of consumer participation that was more relevant for home birth associations than the actual practice under area health boards. In the interview I conducted with members of the Auckland Home Birth Association, Celia argues that: "The disadvantage was that because home birth was so tiny as compared with lots of other concerns, they were able to maintain their prejudices about it and dismiss us (Auckland Home Birth Association interview, 16 June, 1997). The policy arena where home birth activism was more effective was the Health Department who were engaged in setting the service specifications and quality indicators for area health boards' contracts. Home birth association activists sought to ensure that these were oriented to definitions of childbirth as a normal life event for most women (Nicol, 1987; Dahl, 1990). However, the climate of consumer participation under the area health board system favoured consumer self-

advocacy groups like the home birth associations.

These years of community consultation legitimised consumer groups and consumer representatives. Also, it gave consumer groups leverage to exercise power through creating alliances with various interest groups in the health sector. It was the combination of the political alliances between home birth associations, Save the Midwives and midwives who were sympathetic to their demands that lead to the formation of the New Zealand College of Midwives. The style of relationship between domiciliary midwife and birthing woman developed in the home birth networks provided a tested and successful model for reconstructing midwifery practice. It concentrated on the relationship between the midwife and her client, rather than the midwife and the doctor.

A long term activist who participated in the interview I conducted with the Auckland Home Birth Association reflects on home birth activism in the 1980s:

Celia: It's like we always used to laugh in the old days when we went to meetings in each other's houses that we weren't wealthy women, we weren't even necessarily particularly well educated women because of the generation that we came from, but we were influential. And it was a great start to mothering - to feel like you could make a difference, like to write submissions. I mean none of us even imagined how that happened - what the parliamentary process was before that. But we could actually write things and if we united with enough other women who wrote things and got enough going in, we could influence legislation in this country. So, ... we achieved our aims but it also gave us a lot of power as mothers.

(Auckland Home Birth Association interview, 16 June, 1997)

Conclusion

This story of home birth activism in the 1980s demonstrates a complex relationship between home birth associations and 'the state'. Home birth activists' political actions began with a reasonably successful campaign to protect home birth from increased state sanctioned surveillance over the midwives who attended home birth. Activists made assessments of political opportunity structures and concentrated their demands around improving the status and payment for domiciliary midwives. The support of a more open polity to demands from consumer health activists made it possible to effect significant changes over a few years. In 1990, midwives regained the right to practice without medical supervision.

At the same time, home birth activists were 'staking a claim' for consumer participation in policy making. These years of intense political activity nurtured aspirations for more enduring positions from which consumers could have a voice about the health services that they access. However, in 1991, two years after the area health boards were established, a new government embarked on another round of health sector restructuring. In this new system, the forums for consumer participation were either abolished or rendered irrelevant. However, opportunities opened up for a new form of 'participation' - through accessing purchase of service contracts from health services purchasing agencies.

7

*'The paradox of success':
remaking collective identities in the
1990s*

Introduction

The 1990s began on a high note for home birth activists in New Zealand. The new legislation enabling midwives to conduct antenatal care and birth without medical supervision and to gain midwifery qualifications without first training as nurses represented a successful outcome to years of home birth activism. When the Nurses Amendment Act, 1990 was passed, the *New Zealand Home Birth National Newsletter* announced it as "a giant step forward" that would give "the women of Aotearoa a real choice of birthing" (Summer, 1990/1:1). Also, the home birth associations had a powerful new ally in the New Zealand College of Midwives with a leadership who were committed to working in partnership with consumer groups. Furthermore a

number of home birth associations were exploring ways of ensuring consumer involvement in designing regional home birth services, in preparation for when the area health boards were to become responsible for managing primary care.

At the time I undertook the interviews for this research, however, home birth activists were more ambivalent than celebratory about the re-creation of midwifery in New Zealand. For example one participant suggested that “from the home birth point of view, the Nurses Amendment Act was great”, while at the same time it had “overall, a negative impact on the home birth associations” (Celia, Auckland Home Birth Association interview, 16 June, 1997).¹ Another respondent called the Nurses Amendment Act, 1990, a “double-edged sword” (Natalie, Wellington Home Birth Association interview, 25 March, 1997). The very success of the home birth movement in changing institutional practices in maternity services has undermined the capacity for associations to activate collective support for their organisations. Coupled with this, the restructuring of the health system, which began when the National Party formed a new government at the end of 1990, closed down the emerging opportunities for home birth activists to have a voice with respect to maternity services through participatory policy making processes within state agencies.

This chapter examines how the home birth activists I interviewed interpreted and explained the changes to birthing politics in the 1990s. Most of the home birth association groups interviewed in this research were asked in what ways the focus of their group had changed, if at all, since 1990, as well as being directly asked about their assessments of the effects

¹ For a description of each of the associations and interview groups included in this research, see appendix one.

of the Nurses Amendment Act and the 1991 health reforms.² I was looking for, and thus in a sense helped to produce, 'narratives of social change' through the process of conducting these interviews. As an insider in this movement, I knew these issues were often discussed amongst home birth activists. A number of the comments I include in this chapter, however, were not in direct response to these questions. This indicates that for the interview participants the problem of how to account for the changes in maternity services has a life of its own. While the interview participants were asked about their local situation, a marked degree of uniformity emerged in their accounts of the shifts in home birth activism since the beginning of the 1990s. This indicates that the effects of the changes in maternity services have been relatively consistent nationwide and that the networking between different home birth groups, although largely informal and ad hoc, has produced shared interpretations of the reconfigurations in birthing politics.

When I collated what the women who participated in this research said about the shifts in home birth activism in the 1990s, I was surprised by the general negativity of most comments. In some ways, this is what participants in social movements do - they are critical, they seek ways to make sense of problems in order to effect change. In this chapter, this negativity is intensified through the process of bringing together all these comments from different interviews. In each interview, these comments were part of a larger picture of what association members were thinking and doing.

The next three chapters analyse the new directions in collective action

² I did not ask this question in the Eastbourne Home Birth Support Group interview as this group only started in 1992. Also, in the group interview with the Christchurch Home Birth Association, I changed the order of the questions, leaving this one to the end. We ran out of time, so this question was not discussed.

pursued by activists within the home birth associations selected for inclusion in this research. Although it has become more difficult to represent home birth concerns in government maternity policymaking, New Zealand College of Midwives representatives are regularly included in formulating maternity policies. The College's commitment to consumer participation and partnership gives home birth association representatives a voice in determining College policies. The New Zealand College of Midwives has thus become an important, though problematic arena for home birth activism. The next chapter focuses on the complexities surrounding home birth consumer representation within the College. In chapter nine I analyse how some home birth associations are attempting to take up new possibilities offered by the restructuring of the health sector through contracting with health authorities to become 'providers' of home birth services.

The Nurses Amendment Act, 1990

Helen Clark, as the Minister of Health, introduced a Bill to amend the Nurses Act and reinstate midwifery autonomy in November, 1989. At the same time she began reviewing possibilities for establishing direct entry midwifery programmes. In her keynote speech to the first New Zealand College of Midwives conference, Clark explained that she wanted to address the inequitable position of midwifery, as a female dominated occupation, as well as the way that the medicalisation of childbirth had disempowered birthing women (1990:1-2). She told the conference that:

When I became Minister of Health last year I had the opportunity to do something about the injustice which I consider the loss of autonomy for midwives to be. ... I discovered surprising allies. Even the Treasury could see merit in increased autonomy. And if we look at the problem

from the perspective of those officials who have been charged by Government with reviewing restrictions on practice which are in essence anti-competitive, there is certainly a strong argument to be mounted against the monopoly of registered medical practitioners in taking full responsibility for the supervision of childbirth (1990:2-3).

Somewhat ironically, the Nurses Amendment Bill suited both feminist and economic rationalist agendas, although for different reasons. Treasury advisors saw this as an opportunity to introduce competition into an area of primary care. While doctors are necessary for meeting other national health needs, for maternity care for normal births, this does not need to be the case.

Many home birth activists at the time, myself included, thought the bill was a measure specifically aimed at addressing the problems associated with doctors acting as gatekeepers to home births. In some regions, such as Gisborne, Thames Valley, Northland and in rural areas of the South Island, there were continual difficulties in finding doctors who would attend home births (Donley, 1992a:39-41, 73). This interpretation of the Nurses Amendment Act was articulated by Hannah and Tania from the Tauranga Home Birth Association. In a discussion of the effects on the home birth association following the passing of the Nurses Amendment Act, they argue that this legislation 'was about autonomy for *domiciliary* midwives':

Hannah: The home birth movement as a whole, nationally, we put so much into getting more money for domiciliary midwives. I mean that's what the whole 1990 Act was about.

Tania: Yeah. It was about domiciliary midwives. It was not about midwives running around taking on all these hospital clients and getting paid a lot.

Hannah: It was about getting domiciliary midwives better pay, getting recognised for what they do, because they were independent, autonomous practitioners, really. All the GP did was sign a piece of paper basically and

so the home birth movement worked really hard on that and then it happened. So we were really focussed. We had this task and then the task was completed and - what do we do now? ... And it was like all of these midwives sort of came out of the woodwork from everywhere.

(Tauranga Home Birth Association: 25 March 1996)

I will discuss the issues related to a loss of direction for home birth activists after the successful passage of the Nurses Amendment Act, which this excerpt raises, later in this chapter. The view that the Nurses Amendment Bill was about home births was, I think, shared by members of the medical profession and this in part accounts for their relative lack of opposition to it. In the review of the submissions to the Nurses Amendment Bill, the Select Committee notes that the New Zealand Medical Association and the Royal New Zealand College of Obstetricians and Gynaecologists gave cautious support for the proposed changes. They argued that a medical practitioner should conduct an initial antenatal assessment of a pregnant woman to determine whether the pregnancy was 'normal' and that midwives should be supported by 'flying squads' like in the United Kingdom (Social Services Committee, 1990:5). These are teams that include an obstetrician, a paediatrician, a nurse and sometimes an anaesthetist who go out to *home births* when problems arise (*New Zealand College of Midwives Newsletter*, Vol. 2, No. 8, 1990:23).

Leaders from the New Zealand College of Midwives, on the other hand, saw the potential for organising new forms of maternity services, such as a domino midwifery service - where a woman gives birth in a hospital attended by the midwife who provides her antenatal and postnatal care - and midwifery run birthing units. By extending the relevance of the Nurses Amendment Bill to midwives who attended births in hospitals, it offered an opportunity to unite hospital and domiciliary midwives, as well as

professionalising the status of midwives (*New Zealand College of Midwives Newsletter*, Vol. 2, No. 6, 1990:11-13). College representatives lobbied for changes to other legislation to permit midwives to hold access agreements, like GPs, to attend their clients in hospital facilities and to make specialist referrals (Social Services Committee, 1990:9-10). Again, the representatives from the Medical Association and the College of Obstetricians and Gynaecologists did not object, but the summary of their submissions focus on midwives' rights to "transfer patients to an obstetrician or a hospital", rather than the right to for midwives to attend their own clients in hospitals for a normal birth (Social Services Committee, 1990:9-10). Neither the leaders of the medical profession nor home birth activists anticipated the profound consequences that the 1990 Nurses Amendment Act would have for the arrangements of maternity services.³

At the home birth conference in Whangarei in May, 1990, held while the Nurses Amendment Bill was in select committee (Social Services Committee, 1990:4), the conference passed a remit calling for a further change to the Nurses Act, 1977. This Act, which itself is a derivation of the Midwives Registration Act, 1904, and was amended in 1983 to make nursing registration a requirement for domiciliary midwives stated that:

Every person commits an offence and is liable on summary conviction to a fine not exceeding \$1,000 who attends a woman in childbirth in an obstetric nursing capacity in any other place than a licensed hospital within the meaning of the Hospitals Act 1957, unless the person attending the woman is

- (a) A registered general and obstetric nurse and a registered midwife; or
- (b) A registered comprehensive nurse and a registered midwife (Section 54 (3)).

³ Judi Strid, a consumer activist in maternity politics, made this point at a New Zealand College of Midwives conference. She argued that: "The events triggered by the 1990 Nurses Amendment Act have been more profound than anticipated so no one was prepared for the mass exodus of hospital midwives into the community" (1994:93).

This explicitly makes it illegal to practice lay midwifery or for anyone else to be present with the woman and her baby birthing at home, although no one has yet been charged under this legislation. The conference wanted this subsection to be repealed. The remit read:

When the Nurses Act is revised, the Home Birth Groups of Aotearoa urge the Government to decriminalise birth in order to enable all women to birth in the way they choose (*Christchurch Home Birth Newsletter*, Vol. 10, No. 3, 1990:13).

The Nurses Amendment Act was passed in August, 1990, and enabled registered midwives to provide maternity care independently of medical practitioners. It reversed the 1971 amendment to the Nurses Act which had made midwives subject to medical supervision. The 1990 amendment, however, went further. It entitled midwives to provide antenatal care and to hold access agreements with area health boards, to attend their clients during labour and birth in hospital facilities. Midwives also gained rights to prescribe the medicines and order the laboratory diagnostic services that are commonly used during pregnancy and childbirth.⁴ Lay midwifery practice, however, continues to be illegal.

In 1991, two pilot direct entry midwifery training courses were approved by the Ministries of Health and Education and the Nursing Council.⁵ The New Zealand College of Midwives encouraged midwives to take up

⁴ These changes involved amendments to four other Acts; the Area Health Board Act, 1983, the Medicines Act, 1981, the Misuse of Drugs Act, 1975 and the Social Security Act, 1964, 1965, 1981 as well as the Obstetric Regulations 1986 and the Medicines Regulations, 1984 (*Save the Midwives Newsletter*, Spring, 1990:4-8; *Social Services Committee*, 1990:8-12).

⁵ It was the Associate Minister of Health, Katherine O'Regan who coordinated the policy changes necessary for implementing the direct entry midwifery courses. These courses commenced in 1992. One was at the Auckland Technical Institute, and this was a diploma course, while the other one at Otago Polytechnic was a degree course (*Save the Midwives Newsletter*, No. 28, 1993:2-3).

independent practice (see for example Pelvin, 1990:6-7; Guilliland, 1992:1-2). Within a few years, hundreds of midwives left rostered hospital employment for independent practice.⁶ Two years later, a Maternity Benefits Tribunal recommended to the Minister of Health that independent midwives who took responsibility for the overall care of clients should be entitled to claim the same maternity benefit fees as GPs (Maternity Benefits Tribunal, 1993).⁷

The dilemma of how the home birth associations would respond to these opportunities for midwives to offer a new range of maternity services was intensively discussed at the home birth conference following the Nurses Amendment Act, 1900. Held in Nelson in May, 1991, it was attended by about 80 people, representing 15 of the 20 home birth associations in New Zealand at the time (*Nelson Home Birth Association Newsletter*, June, 1991:4).⁸ The Auckland Home Birth Association delegates wrote that:

⁶ There are no accurate statistics about the numbers of independent midwives practising in the 1990s. The National Health Committee cites the numbers of midwives claiming off the Section 51 maternity benefit schedule has remained fairly constant at around 780 since 1996 (1999:44).

⁷ Midwives were able to claim off the maternity benefit when the Nurses Amendment Act took effect. However, the Maternity Benefit Tribunal was significant because the New Zealand Medical Association had by then organised a counter-mobilisation against midwifery autonomy. They argued that midwives claiming the same fees under the maternity benefit should be seen as an interim arrangement and that the maternity work, skills and qualifications of midwives were not the same or of equal value to those of doctors. The New Zealand College of Midwives, home birth associations and other maternity action groups constructed the level of fees as a pay equity issue. More effectively perhaps, College leaders also utilised the language of the new economic discourses. They argued that the work of doctors and midwives was of equal value because the 'outcome' - a safe successful normal birth - was the same. They pointed out that under the Public Finance Act, 1989, which also pertained to the health sector, funding was to be based on 'outputs' rather than on 'inputs' (Maternity Benefits Tribunal, 1993:15-17).

⁸ I did not attend this conference. The Christchurch Home Birth Association sent four members. I was particularly interested in the debates which emerged at this conference because I was employed part time by the Christchurch Home Birth Association as an antenatal coordinator. Thus questions about the future direction of the home birth associations were relevant to my work.

There was no ambiguity as to the function of the Conference - this was definitely a working conference, not a public showcase and the bulk of the time was devoted to facilitated meetings (*Home Birth/ Whanautanga*, No. 51, 1991:13)

This conference can be viewed as one of those 'contexts' Ann Swidler writes about where "the dynamics of the meetings can give ideas a coherent systematic influence, even when the individual participants are confused or ambivalent" (1995:35). Some of the decisions that were made at this conference established the direction for home birth association politics in the 1990s.

One contentious question that was discussed at this conference was the relationships between the home birth associations, domino midwives and the women who chose this option. Some home birth midwives had begun offering the domino option for clients. The associations that played a role in putting women in touch with midwives, questioned whether they should also supply information to women about domino midwifery and review domino midwives through the domiciliary standards review committees. The members of the Whangarei Home Birth Association decided to promote both home and domino birthing and, therefore, changed the name of the group to the Birth Support Group shortly before the conference. This was in response to local conditions in Northland where the demand for home birth was not large enough to support midwives working exclusively in a home birth practice (*Home Birth/ Whanautanga*, No. 50, 1991:37).

Some home birth association members argued many women might choose a domino birth as a stepping stone for planning a home birth with their next baby. They saw this as a reason to make links with women who chose this option (*Home Birth/ Whanautanga*, No. 51, 1991:14). Others argued that the interests of women who chose home births and those that chose domino might not necessarily coincide (*Christchurch Home Birth*

Newsletter, Vol. 11, No. 3, 1991:7-8). For example, in February, 1991, Treasury issued a press release warning about a maternity benefit 'blowout' (*Sunday Star*, 24 February, 1991). Following the Nurses Amendment Act, many women who sought independent midwifery care for birthing in hospitals also wanted a GP to be involved.⁹ Both the midwife and the GP could claim the maternity benefit. While the home birth associations supported two practitioners for a birth at home, this was not, from their perspective necessary for women birthing in hospitals where other staff were available to act as a second practitioner at the birth.

Within the home birth networks, the form of home birth practice which had been developed in the 1980s was based on 'women led' care and women's choices for birthing. This frame had been articulated in a context where home birth could be constituted as the only active 'choice'. Home birth activists, simultaneously demanded the right to birthing choices on behalf of *all* women and improvement in birthing services for a small group of women who wanted to birth at home. The former justified the latter. Now women with different orientations to birthing could exercise choices in ways which undid the distinctiveness of home birth as an alternative.¹⁰

Another troubling issue for home birth activists was that some midwives who had previously worked in hospitals were interested in attending home births, but did not necessarily have an understanding of the home birth

⁹ Marjet Pot and Linda McKay, from the Auckland Home Birth Association, collated statistics about independent midwives in Auckland. They report that in 1991, 37 births at National Women's Hospital in Auckland were booked with 'midwife only' independent midwives, in comparison to 597 births booked as shared care between a midwife and a GP. By 1994, there were 1910 midwife only and 2162 shared care births, which together represented just over 20% of all births at National Women Hospital (1996:n.p.). Guilliland estimated that in 1997, 65% of birthing women chose 'midwife only' care (1998:4).

¹⁰ Some association activists were, however, sceptical of claims that midwives and birthing women could be "equal partners in hospitals" - which they regarded as sites of medical control (*Home Birth/ Whanautanga*, No. 51, 1991:14).

associations' codes and ideals of practice. The representatives from the Thames Valley Home Birth Association, for instance, reported of a new independent midwife in their area who offered home birth, but had "problems with our home birth philosophy and allowing women choices" (*Home Birth National Newsletter*, Autumn/ Winter, 1991:23). In an address to the conference, Bronwen Pelvin, a domiciliary midwife from Nelson also expressed this concern:

With the changes in the law, we are now seeing hospital, medically oriented midwives drawn into home birthing. We've always been here actually because all of us have had to go through our own un-learning process in relation to birth. ... And [this] can only be done with midwives acknowledging that their teachers are the women having babies. Which is a bit of a leap from learning everything about birth at the doctor's knee, in a hospital! (*Home Birth National Newsletter*, Autumn/ Winter, 1991:22)¹¹

These comments from Pelvin articulated and added fuel to the ambivalence and mistrust some home birth activists felt about the entry of these new midwives into home birth. The 1980s home birth catch phrase that "the interests of mothers and babies and the interests of midwives coincide" became problematised (*Save the Midwives Newsletter*, No. 1, 1983:14). As I argued in the previous chapter, the idea that midwives and birthing women had unitary interests rested on defining those midwives who worked in hospitals as 'nurses'. Through the debate about domino midwives, some home birth activists sought to draw a new distinction between 'home birth' and 'domino' midwives (*National Home Birth Network Newsletter*, October, 1992:10). They disputed the New Zealand College of Midwives' argument that 'a midwife is a midwife is a midwife', that is, registered midwives are independent practitioners no matter where

¹¹ This speech was reprinted in both the *Taranaki Home Birth Association Newsletter*, August, 1991:7-12, and the *Christchurch Home Birth Association Newsletter*, Vol. 11, No. 5, 1991:14-16.

they work (see for example; Guilliland, 1990:1-2, 1994:6). For the College, this position helped create and sustain solidarity ties between midwives who offered different kinds of birthing services and thus was, and continues to be, a critical aspect of their collective identity. It, however, posed difficulties for home birth activists who had an investment in the specific form of midwifery practice which the home birth midwives and consumers collectively constructed in the 1980s.

The conference report in the Auckland Home Birth Association newsletter noted that the: "Home Birth Associations need to be clear that their primary purpose [is] to support and promote the philosophy and reality of homebirths ... where women and midwives are equal partners in the whole process" (*Home Birth/ Whanautanga*, No. 51, 1991:14). Part of this included attempting to protect the meanings and practices of home birth from cooption by midwives who did not have existing connections to the home birth associations (*Home Birth/ Whanautanga*, No. 51, 1991:14).. Rather than seeking to include women and midwives who might share aspects of home birth collective action frames with respect to close ties with midwives, consumer participation and empowerment, even though they chose to birth in hospitals, the conference participants reconstructed a more exclusive collective identity.

A key issue for some of the home birth activists was that they feared they would lose the forms of control they had over home birth. Through the interdependent relationships between home birth associations and their local midwives during the 1980s, many home birth activists had acquired a sense of 'ownership' and responsibility for the home birth services in their area. The successful achievement of professional autonomy by midwives, which made it possible for midwives outside home birth association networks to offer home birth services potentially undermined the networks through which home birth consumers had exercised informal control over

the services offered by domiciliary midwives.

Home birth association activists' desire to maintain consumer control over home birth services was heightened by their assessments of the political opportunity structure. At the time of the May, 1991 home birth conference, activists in a number of associations were engaged in crafting a position to maximise their capacity to represent home birth claims within area health boards. They saw possibilities for associations to work with area health boards to ensure home birth services met consumer expectations. These debates about 'territorial boundaries' and collective identity, thus had wider strategic implications for home birth activists. Shortly after this conference, the Government announced another round of health sector restructuring (Upton, 1991), which consequently altered the political opportunity structure.

Restructuring health and maternity services

The 1991 'health reforms' replaced the 14 area health boards with four government appointed regional health authorities who purchased health and disability services, including primary health services, on behalf of the people in their area, (Upton, 1991). The elected area health boards were abolished and over the next two years the existing area health board hospital facilities were divided into crown health enterprises (CHEs). These were expected to run as efficient and competitive businesses, and until October, 1996, return a profit for the government (Ministry of Health, 1998:3).¹²

¹² The regional health authorities have since been amalgamated into one 'Health Funding Authority', with regional branches, established on the 1 January, 1998 (Ministry of Health, 1998:4)

The 1991 round of health restructuring shifted health policy clearly in the direction of a managed competition through quasi-markets for health and disability support services (Cheyne, O'Brien and Belgrave, 1997:227).¹³ Regional health authorities could contract to purchase health and disability services from private, publicly owned and voluntary sector providers. Also envisaged in the health reforms was the possibility for future competitor purchasing agencies - 'health care plans' - which people could elect as their purchasing agent instead of the regional health authorities (Upton, 1991:65-73). The 1991 health reforms were premised on the neo-liberal argument that providers, in competition with each other over contracts for government funding would make the New Zealand health system more efficient and cost effective. Advocates of the reforms argued that this new funding arrangement would rid the health system of excessive bureaucracy, lead to greater consumer choice and foster more individual responsibility for healthy lifestyles (Upton, 1991:9-10).

The rationale behind splitting the funding from the provision of health services is based on agency theory (Ashton, 1992:154-155).¹⁴ According to agency theory, for effective, efficient management, policy formulation and direction needs to be clearly separated from the management and delivery of services. Like the owners or shareholders in the private sector, ministers or other policy/funding agencies (principals) should determine policy objectives and then contract managers (agents) to implement them (Sharp, 1994:6, Cheyne, O'Brien and Belgrave, 1997:86-87). Agency theory employs another set of categories - distinguishing between 'inputs' and 'outputs' or 'outcomes' and suggests that funding decisions should be

¹³ Cheyne, O'Brien and Belgrave, (1997:85-86) suggest that 'quasi-markets' differ from free markets in that the ownership structures of providers are less clear, and purchasing decisions are made by agents, such as a Regional Health Authority, rather than by the consumers themselves.

¹⁴ New Zealand political commentator, Colin James asserts that agency theory should not be subsumed under libertarian thought, although it is often seen by critics as allied to it (1992:88-89).

based on outputs and outcomes, rather than tied to pre-allocated bulk funds or inputs (Nowland-Foreman, 1995:1-2). Through this model of health service purchasing, Geoff Fougere argues, the government "intended to diminish the control of doctors and other providers within the health system" and increase the government's capacity to control the health budget and the range of publicly funded health services (1993:121).

One of the reasons given for abolishing the elected area health boards was that they were "hampered by the politicisation of the decision making process". The Minister of Health argued that "vehement protests from numerous interest groups, and public campaigns ... often effectively paralyse[d] boards' ability to take decisions" (Upton, 1991:9; see also National Interim Provider Board, 1992:9). Martin, a critic of these reforms, suggests that the advocates of these reforms believed that the dual lines of accountability of the area health boards "to their local constituency on the one hand, and to central government, the paymaster, on the other - was fatally flawed" (1991:22). Instead, in the restructured health system, the regional health authorities were not directly accountable to consumers, only to the Ministry of Health. However, under the Health and Disability Services Act, 1993, these agencies are charged with consulting the public "as the authority considers appropriate" (Section 22). This Act established an "arms-length funding relationship" between the Minister of Health and regional health authorities, such that the Minister could not directly interfere in the contractual arrangements made by the health authorities (Upton, 1992:9). As one long term home birth activist put it:

Celia: The National Government was very clever when they set up the RHAs. They wanted a buffer between the Minister and the Ministry *and* the consumers. So they set up the suits in the middle. ... And you can kick and throw stones and all sorts of things, but they are completely, sort of impermeable.

(Auckland Home Birth Association interview, 16 June, 1997)

This was a significant change in the political opportunity structure for home birth activists whose lobbying skills and contacts had centred on Members of Parliament in the 1980s.

The restructuring of the health system had an indirect, rather than a direct effect on home birth services. The most important direct effect was that the reforms prompted some home birth associations to tender for contracts with their regional health authority, although this possibility had already opened through the area health board structure. The government did not bring in user part charges for hospital maternity services, which is interesting, as the July 1991 budget introduced user part charges for all other hospital services (Shipley, 1991:59-68). The protracted negotiations between the regional health authorities, the New Zealand College of Midwives and the New Zealand Medical Association over the maternity benefit - now covered by 'Section 51 of the Health and Disability Services Act, 1993' - also did not significantly impact on home birth services.¹⁵ On the other hand, the transformations of health funding and organisation have changed the 'environment' of the health sector in ways that are problematic for home birth activists.

¹⁵ In 1994 and 1995 drafts of Section 51, funding for home help following a home birth was included in the schedule of fees. This was dropped from the final 1996 notice. The regional health authorities had determined a capped budget for the overall expenditure on primary care maternity services and the home help funds were redistributed into professional fees. Home birth associations have lobbied for home help since the early 1980s. It is included in the home birth services offered under the Community Birth Services/ Manawatu Home Birth association contract, and between 1993 and 1998 the Tauranga Home Birth Association had a contract with the Midland Regional Health Authority to provide home help for home birth families. It has not been available elsewhere in New Zealand. The omission of home help from the Section 51 notice represented the loss of a potential rather than an actual service.

The unintended outcomes of success: losing political focus

Through the 1990s, some home birth associations have ceased to function, for example, the Nelson Home Birth Association ceased to operate at the end of 1996. Others are struggling to maintain an active committee as well as broader membership, a problem that was identified by participants from the Auckland, Tauranga, Wellington, Christchurch and Dunedin interview groups. At the same time, new home birth groups have emerged, such as the Eastbourne, Upper Hutt and South Canterbury Home Birth Support Groups, and women in Whangarei reactivated a Home Birth Support Group. In most of the interview groups, participants said that the emphasis of their group has shifted from political lobbying to providing resources and services for members in their region. The new groups are more explicitly oriented towards support and services for members.¹⁶ Most home birth associations and support groups continue to try to draw women who want to birth at home into networks through which the home birth 'philosophy' and practical knowledge that has been generated and tested out by women/ families birthing at home can be circulated. Some groups are involved in more formalised service provision through state funded contracts for various home birth services, such as antenatal classes, midwifery services and postnatal home help.

Several of the long term activists who were interviewed considered this shift from a political to a service oriented focus as a 'loss' and as a significant change in the 1990s for their home birth group and/or the home birth movement more generally. For example, Celia comments that:

¹⁶ For example, the Eastbourne Home Birth Support Group organises a voluntary service to provide meals in the first days following a planned home birth (women can still access this even if transfer to hospital was necessary). The Upper Hutt Home Birth Support Group made a video about fathers in 1998 (*Wellington Home Birth Association Newsletter*, No. 172, 1998:6).

Celia: When we joined, the direction of home birth was so much clearer than it is now. Like the mission was so obvious. I think that's one of the reasons why our active membership is so low - it's not obvious what the home birth association does or why it exists. Whereas before it was. It had to exist.

(Auckland Home Birth Association interview, 16 June, 1997)

The Nurses Amendment Act 1990 and the ways in which many midwives have used this as an opportunity to change the ways in which they practice has decentred the 'insurgent' collective identity of the home birth associations. This, Celia suggests has reduced the capacity of association networks to attract new members. A participant in the Southland Home Birth Association interview also stated that: "A lot of women don't see why they need to join. ... [They] are not politically motivated because the freedom is there to do it" (Heather (midwife), Southland Home Birth Association interview, 6 October, 1998).¹⁷ Similarly, Natalie from the Wellington Home Birth Association interview group suggested that "the problem" with the Nurses Amendment Act was that it has made home birth "accessible to being almost a mainstream option". As a consequence, Erica argues, women who birth at home are less interested in joining the association:

Erica: You find they [women who plan to birth at home] join perhaps because they have a special relationship with their midwife and they want to support her, but it's less because of a political - or because they think that home birth might disappear for their children or whatever. It doesn't even cross their minds that it might be a temporary thing. ... People don't see any reason to join up.

¹⁷ While most of the participants in the interviews were consumers, a few home birth midwives were involved in some interview groups as well. Whenever a contribution to the discussion from a midwife is used, it is noted. The rest of the comments come from consumers.

(Wellington Home Birth Association interview, 25 March, 1997)

Erica suggests that those women who now join the Wellington Home Birth Association do so for different reasons than women who joined before the 1990 changes to the Nurses Act. Erica's comments are also indicative of the contingency in the meanings that can be attributed to 'joining the local association' and 'supporting the domiciliary midwives'. In the context of the struggles over home birth and the very low rates of pay for domiciliary midwives in the 1980s, personally supporting 'their midwife' had political implications which were more 'obvious' to potential members.

Erica and others in this interview group suggest that the future of home birth is not necessarily assured. This fear was also expressed by participants from the Manawatu Home Birth Association:

- Judith: I think a lot of people see home birth almost - not as main stream - but there's a perception by some people who accept it that it is a battle won. And in fact I don't think that's true. Until it's a lot more prevalent than it is now, it is not a battle won, it's -
- Nicole: open to being reversed.
- Judith: Yeah, maybe it's a battle won but it's not the war won.
- Others: Yeah, yeah, right.
- Judith: And people don't realise that. And maybe that's why home birth associations around the country are getting kind of - the numbers are dwindling.

(Manawatu Home Birth Association, 24 March, 1997)

Members from the Manawatu Home Birth Association argued that ongoing collective action is necessary because the current acceptance in some circles could be temporary and subject to reversal. One potential 'threat' to home birth, participants from this group suggested, is that hospitals or medical practitioner associations might seek to include a home birth service in their maternity service contracts with health funding authorities. Then, as contract holders, medical specialists and managers could

determine who would be able to access home birth services and what these services would encompass.

The Nurses Amendment Act has changed the home birth networks in another significant way. In most interviews, participants talked about the distancing effect it has had on the relationships between home birth association consumer members and home birth midwives. Natalie, from the Wellington Home Birth Association suggested that since the legislative changes “we have lost the cohesiveness of the midwives and the consumers” (25 March, 1997). This was echoed by Kate, in the Dunedin interview, who commented “we used to have close affiliations with midwives in the past, but we seem to be losing our midwives” (25 March, 1998).

In the previous two chapters, I argued that the collective identity of the home birth movement constructed home birth as a ‘site’ where domiciliary midwives and consumers worked closely together. This occurred in the context of birthing as well as within home birth networks and in the political lobbying by the home birth associations. This was, on the one hand, a consequence of the conditions of the formation of the home birth movement in New Zealand where women birthing at home and midwives were mutually dependent on each other. It was also shaped by the political opportunity structure which pushed activists to base claims on the state for better access to home birth services through seeking to improve the working conditions for domiciliary midwives. After gaining autonomy and an outspoken national professional body, midwives no longer had the same need for home birth associations to support their practice and to challenge the opposition to home birth.

William Gamson and David Meyer contend that favourable outcomes of social movement campaigns can have contradictory effects in terms of how

movement participants assess the relative openness of the political opportunity structure. Successes may generate optimism about the potential for more change, as supporters feel that "history is on their side" (1996:286). Alternatively and often simultaneously, movement participants may doubt that continued activism can produce further gains and may even have concerns that it might provoke perverse effects, such as the loss of allies (Gamson and Meyer, 1996:286-287). In the early 1980s, the effectiveness of the home birth lobbying against efforts by leading obstetricians and nurses to exert more control over home birth lead to an increase in home birth activism. It encouraged people involved in the home birth movement to believe that further changes were possible and reinforced sentiments of the worthiness of their cause. The success in achieving midwifery autonomy from the medical profession and pay equity seems to have had the opposite effect. It has become more difficult to activate those people who are interested in birthing at home to join the organisations that are seeking further improvements in home birth services.

The members of the home birth associations whom I interviewed saw a continuing role for the associations both to protect these gains from reversals and press for more acknowledgement of consumer voices in the policy making, monitoring and administration of maternity services. Their commitment to active participation in the home birth associations is indicative of a collective and political orientation to birthing. Home birth activists utilise various strategies in their attempts to make sure that future changes will be beneficial for women who want to birth at home. These strategies of continued home birth activism, however, occur within a context where deployments of power have become more elusive, more difficult to define and translate into readily understandable collective action frames to mobilise more support.

Do social movements only thrive under adversity? The long term home

birth activists I interviewed share an interpretive narrative of a home birth movement that flourished when home birth was constituted as an alternative practice and a site of political struggle. Some of the participants in this research even talked about the 'home birth movement' in the past tense.¹⁸ However, members of the Wellington Home Birth Association also talked about new overwhelming conditions of adversity which they believed discourage people from actively participating in their local Home Birth Association.

New constraints for political interventions were mentioned in several of the interviews, but these were discussed at length by the interview group from the Wellington Home Birth Association. The participants shared stories of unsuccessful attempts at challenge state authorities in relation to several issues, as an association and in other political groups in which members are involved. This closing down of opportunities for political interventions is particularly pertinent for the Wellington Home Birth Association. In the late 1980s and early 1990s, activists from the Wellington Association, because of their location in the capital, were included in or consulted by several Health Department policy committees setting new guidelines for maternity services. Home birth activists in Wellington also made direct links with Members of Parliament.¹⁹ Now, the interview participants argued, this has changed significantly. The Wellington Home Birth Association, furthermore, was unable to get a contract to provide home birth services, although the Manawatu Home Birth Association received one from the same regional health authority.

Natalie's and Jan's following comments were made in response to Erica's point that women seemed less politically motivated to join the Wellington

¹⁸ See chapter two.

¹⁹ *Wellington Home Birth Association Newsletter*, No. 88, 1990:11; No. 93, 1990:7; No. 99, 1991:8; No. 101, 1991:17-18.

Home Birth Association committee:

Natalie: With the shift to the 'right', everybody's becoming much more isolated. ... The people who earn the money in the household have to do so much more time - there isn't the time to put into community work or voluntary work.

Jan: That's another possible problem - the difficulty that the energy level seems quite low to crank up to do things. ... I agree with what Natalie was saying - the reason being that people seem dislocated, ... and localised, at this time. ... [With] the New Right changes, because so much has been bulldozed through that people have lost their voice in quite a lot of different ways and they've sort of become really passive and you can't - you feel like a very, very small cog, without any ability to change things. And then you end up saying "well what's the point, where do we start, there's so much going on". What do you say to the Government to reverse these New Right changes going on? People have lost their democratic voice in a lot of ways, so it seems like a lot more effort and there is a lot more cynicism about going to try to do anything.

...
Natalie: With the change in the policies - it feels very much more like that with the lobbying too - a whole lot of brick walls are out there now that didn't used to be there. ... You reach a point when as a group, you've tried to go through the system to do it a particular way, if you keep on hitting the same brick wall, eventually you just stop trying.

(Wellington Home Birth Association interview, 25 March, 1997)

This discussion makes several interconnected points. Firstly, Natalie and Jan suggest that people have less time to put into community networks and are more isolated from each other.²⁰ Also, they argue that the political structure is less conducive to social movement activism and therefore

²⁰ This argument was also made by Juliet and Kathryn in the Dunedin Home Birth Association group interview (25 March, 1998). Like members of the Wellington Home Birth Association, they saw this as connected to new right government policies, although Juliet also argued that "many women go back to work or study when their children are still quite young" out of choice.

people have become 'passive' and 'cynical'. The 'brick walls' that Natalie refers to include managers from the Central Regional Health Authority and the local maternity hospital, who Natalie and others in this group argued, have seemed impervious to their demands.²¹ They also talked about incidents where they complained about decisions made by intermediary state bodies to Government Ministers. For example, Helen and Natalie related how they approached the Minister of Broadcasting to intercede in the New Zealand Broadcasting Corporation's decision to take a children's radio programme off air. They were told by the Minister that he "was not allowed to politically influence" these kinds of "technical" decisions (Wellington Home Birth Association interview, 25 March, 1997). Thus, members from the Wellington Home Birth Association suggest, even if they had a larger active group of politicised women, they would still not be able to achieve very much in political policy arenas. This was summed up for them as an effect of the "shift to the right".

Christopher Pollitt, who analyses the effects of the increasing utilisation of neo-liberal and managerialist discourses on the British National Health Service, makes the argument that these are being introduced at the cost of discourses of 'citizenship'. He suggests that:

Citizenship is an awkward concept for the new right neo-liberals, and an almost absent one in the managerialist literature. ... It is a concept with strong connotations of collective rather than individual action. Citizens owe duties to and possess rights of the state. All this is alien to the individual model where the market is the chief focus of transactions and values, a market which, in principle, knows no frontiers (Pollitt, 1990:129).

Citizenship is a concept, Pollitt argues, that can not easily be

²¹ Accounts of unsatisfactory interactions with regional health authority managers were also presented by members of the Tauranga, Christchurch and Southland Home Birth Associations.

accommodated in liberal economic thought. However, the rights for citizens to "justice, representation, participation and (more recently) equal opportunities ... are, indeed, the rights which many citizens seek to inscribe in the organization of their public services" (Pollitt, 1990:129; see also Hall and Held, 1990:178-180). The members of the Wellington Home Birth Association offer a similar analysis of the shifts in government policies in New Zealand over the last decade. In their view, the restructuring of the public services along neo-liberal lines has reduced opportunities for the deployment of citizen rights claims. Certain policy decisions that they argue should be made through participatory democratic processes have been redefined as 'technical', managerial decisions that should be left to experts. Those home birth activists who have a critical perspective on the deployments of medical expertise and struggled to open political spaces for consumer voices in maternity services in the 1980s are wary of this shift in policy making processes.

Gamson argues that the effectiveness of a collective action frame in mobilising support for a movement is tied to the persuasiveness of its definitions of the 'adversaries' who perpetuate 'injustices', the attractiveness of the collective identity for movement participants and its 'promise' of the possibilities for change (1992a:7-8; see also; McAdam and Snow, 1997:xxiii; Snow, Rochford, Worden and Benford, 1997 (1986):236). The interviews with home birth association members indicate that it is difficult to maintain a challenging collective action frame when many potential supporters assume that 'enough' change has been achieved, others believe collective action to be futile and the modes of power have become too complex and messy to represent through a simple, immediate collective action frame.

New complexities in 'choices for childbirth'

Members from the Auckland and Wellington Home Birth Associations identified the changes in the practices of midwifery as another problem for home birth activism. While home birth activists at the 1991 conference of the Home Birth Associations of Aotearoa/ New Zealand did not anticipate how the Nurses Amendment Act 1990 would undermine the political drive of home birth activism, they suspected that the range of new birthing options available to women threatened their collective identity. Women could now take features that had previously been distinctive to home birth and recombine these with a more medical orientation to birthing. This was succinctly articulated in some of the interviews conducted with members of home birth associations:

Celia: The Nurses Amendment Act, I think, had really, probably, overall a negative impact on the Home Birth Associations because from the end of 1990 it meant that women who were going to hospital could have, if they were lucky, access to the same level of midwifery care that women had previously only been able to get at home. They could get midwifery continuity of care from the midwife of their choice and for a lot of women that meant having the best of both worlds per continuity of care and going into hospital - just in case.

(Auckland Home Birth Association interview, 16 June, 1997)

Angela (midwife): One interesting thing is that we haven't had the increase in home births that everybody thought there would be. There's a lot more people now in this sort of middle ground sort of shared care, people who are aware that there are things going on in hospitals and don't want to have too many interventions and things like that, and with the law reform think "great, I can have a home birth in hospital, I can have a domino midwife, and I can have my baby in hospital".

Natalie: The only way you used to be able to have an independent midwife was by booking a home birth ...

And now there are many, many ways you can book so that you know who your caregiver in labour will be.

(Wellington Home Birth Association interview, 25 March, 1997)

These two passages make the same point. Whereas, prior to the changes in the legislation, the only way to access continuity of care from a midwife was through planning a home birth. Now birthing women, who do not want a home birth, or even necessarily a natural birth, can choose to have this kind of midwifery care. Also birthing women can now exercise choices for forms of interventions and pain relief that home birth consumers in the 1980s did not consider, but also were not able to access.

Ironically, the possibilities for these increased birthing options are, in part, an outcome of home birth political activism in the 1980s. The shifts which have taken place in birthing illustrate Ann Swidler's (Swidler, 1995:25, 32-39) and Joseph Gusfield's (1994:69) contention that the cultural effects of social movements are not necessarily in changing widely and deeply held cultural beliefs as much as shaping how certain actions are interpreted (Swidler, 1995:33). Home birth activism was not as successful in convincing large numbers of women to birth at home as it was in prompting women to question which maternity services they wanted.²² What home birth association activists, in conjunction with other maternity groups, achieved was to popularise the rhetoric of 'choices for childbirth'.

Carol Mueller argues with respect to the feminist movement that the very success of the movement in disseminating particular collective identities means that feminist identities become 'public goods' (1994:244, 256; see

²² No accurate figures are available on the numbers of home births in New Zealand. The National Health Committee estimates a home birth rate of "about 5%" (1999:46). In 1989, the year before the Nurse Amendment Act was passed, planned home births represented 1.6 % of all births (Abel and Kearns, 1991:827).

also; Friedman and McAdam, 1992:157-158, 166-169). Verta Taylor and Nancy Whittier suggest that:

Collective identities are rooted in social movement communities. But they can also become disembedded from the context of their creation so they are recognizable to outsiders and widely available for adoption (1995:173).

While this signals varying degrees of public acceptance of this identity, it severs the links of dependency on movement networks for those who 'identify' with this identity. The decoupling of the identity of a 'home birther' from the collective networks of the home birth associations diminishes the capacity for associations to attract participants and exert control over the constructions of this identity. The availability of a range of birthing options, which women can choose according to their preferences, makes it difficult to sustain constructions of home birth as a distinctive and challenging act.

For activists like Celia, Angela and Natalie, whose comments are included above, this adoption of the language of 'choices for childbirth' by birthing women who are not interested in, and may even be critical of home births is a 'problem' and a threat to the practices of birthing at home that were crafted in the 1970s and 1980s. Tilda, an early member of the Christchurch Home Birth Association who is no longer involved, argues that this has also changed the way women approach home birth:

Tilda: [A home birth midwife] predicted things would change so much with the passing of that Bill - that there would be more problems with home birth - because women would not be so committed - and not have so much contact with the group and that commitment to the group. With home birth becoming more open, it has become a fashion. Women take it up without the commitment and they have more problems - with the birth and with their care.

(Individual interview, Christchurch, 31 May, 1998)

Tilda suggests that birthing women need home birth networks to become a particular kind of 'subject' with trust in their own capacity to birth and to make decisions and trust in the midwife who attends them. This, Tilda argues, leads to better birthing outcomes and more positive relationships between birthing women and midwives. Tilda argues that since the changes to the Nurses Amendment Act, 1990, home birth has become a 'fashion' and women no longer feel the need for connections to a group that supports this option for birthing. Later in the interview she talks about how the act of having a baby at home in the 1980s meant "standing up for something you passionately believe in. ... Now home birth isn't a political act" (Individual interview, Christchurch, 31 May, 1998).

Tilda is critical of the way in which home birth has become what some theorists refer to as a 'lifestyle' choice (see for example; Stein, 1995; Hennessy, 1993). As these choices become expressions of individual orientations towards birthing, home birth becomes a 'lifestyle' choice. Rosemary Hennessy argues with respect to the new 'queer' identity politics that:

"Lifestyle" obscures ... social hierarchies by promoting individuality and self-expression but also a more porous conception of the self as a "fashioned" identity (1995:165).

In the previous chapter, I argued that the home birth movement was oriented to regaining power and control for birthing women. However, the relative 'success' in realising this goal remakes the meaning of home birth. It becomes part of the commodity culture wherein identity is constructed out of practices of consumption - a consumer choice from a range of birthing options. Paula Treichler argues that this has been one of the unintended consequences of the natural childbirth movement in the United States. She writes:

Ironically, perhaps this "demedicalization" moved childbirth out of the private sphere where women's reproductive and domestic labour have traditionally been positioned: more overtly visible in the public sphere, child birth can more easily be represented as a commodity, not only in the economic marketplace but in the ideological and social marketplace as well (1990:131).

Conclusion

The recurrent theme of the 'loss of political focus' in the group interviews with home birth association members is indicative of the extent to which the meaning of 'political' for home birth activists has been tied to making claims on state arenas. The disillusionment that home birth activists expressed in the interviews in relation to the possibilities for challenging collective action in the 1990s is, in part, an effect of state responses to home birth movement activism. I have argued that as a consequence of the changes in the state regulation of midwives, home birth activists' demands for consumer control in birthing and participatory policy making in maternity services have lost some of their radical force. The discussion among the interview participants from the Wellington Home Birth Association links the depoliticisation of home birth to a wider reprivatisation strategy (Fraser, 1989:172-175). That is, the introduction of market discourses and practices into the state sector and state funded services, has diminished the opportunities for participatory democratic policy making.

The changes in home birth activism in the 1990s are, however, more complicated. The strategies of intensive publicity and political lobbying produced perverse effects. The adoption of the home birth activists' rhetoric of 'women's right to control in birthing' by birthing women who seek different forms of maternity care from home birth undoes the

distinction between home and hospital birth. Home birth can now be constructed as a 'lifestyle' choice, one among a number of birthing choices. New generations of birthing women, at least in urban areas, no longer have to struggle to access a home birth service.

In the face of continual change in the health sector and an uncertain future, some activists are concerned that the loss of politicised home birth organisations may leave the practices of home birth developed in the submerged networks of the movement vulnerable to countermobilisations. These might include groups of doctors or institutionally based providers who take over, or 'coopt' home birth, or, alternately seek changes in government policy to regain control over determining which birthing women can access home birth services. The discussions from the group interviews included in the chapter demonstrate that home birth activists in the 1990s do not have a unified, transparent collective action frame, as they did in the 1980s, to challenge these potential threats. Instead, as I will argue in the next four chapters, a range of responses have emerged. These are specific to different external contexts and locally variable - dependent on the collective identity produced by those who are active members of each particular home birth organisation.

8

'Women need midwives need women' - home birth associations and the New Zealand College of Midwives

Introduction

The midwives who formed the New Zealand College of Midwives in 1988 were committed to a form of practice and a feminist organisational structure that rejected the hierarchy inherent in the way professions had historically grounded claims to expertise (Pelvin, 1990). "Doing professionalism differently", Liz Tully argues, has enabled midwives to distinguish the midwifery profession from their professional rivals - doctors and nurses (1994:54). College leaders advocate a model of midwifery practice based on 'partnership' between consumers and midwives. This embraces both the relationships between individual midwives and individual women, and at an organisational level, includes consumers as

members of the New Zealand College of Midwives. The questions addressed in this chapter are how does this work in practice? Is partnership of less importance as midwifery becomes established as an autonomous profession? What do home birth activists have to say about their relationship to the College?

I begin this chapter with an outline of the organisational structure of the New Zealand College of Midwives. Then I examine some of the complexities in the rhetoric and practices of partnership within the New Zealand College of Midwives with particular attention to the difficulties consumer representatives from the home birth associations discussed in the interviews. The final section explores another way in which the success of home birth activism in the 1980s has undermined the network forms through which new people would join the associations.

The structure of the New Zealand College of Midwives

The New Zealand College of Midwives is divided into ten regions. The regions have considerable autonomy in dealing with local issues. National concerns, such as consultation on government policies and negotiations with respect to the maternity benefit/ Section 51 are handled by the national committee. The regional committees, in a similar way to the general organisational structure of home birth associations, include some office holders and sub-committees. However, decisions are made through consensus by those members who are present at meetings. These meetings are open to all members. Thus, any consumer who is a member of the College, either individually or through belonging to an organisation that is a member of the College, can participate in the decision making. The onus is on consumers who are interested to attend these meetings.

The home birth associations that participated in this research had varying degrees of commitment to attending College meetings. The Auckland, Tauranga and Christchurch Home Birth Associations had the closest connections to the local branches of the College. Members of the Wellington and Dunedin Home Birth Associations had contact with the College through the midwifery standards review process but, at the time of the interviews, did not have any members on their committees who were interested in attending College meetings. This, it was argued in both groups, was because no member of their association was interested or able to make the commitment to attend College meetings.

Participants from the Southland Home Birth Association interview group discussed a problem they faced in being involved with their regional College which reflects a problem with this organisational structure. There are very few midwives in Southland and, at the time of the interview, the meetings tended to be called on an ad hoc basis through informal connections among the midwives who might be interested when issues needed to be discussed (Southland Home Birth Association interview, 6 October, 1998). As participation occurs in the context of meetings, not having advance notice of these forecloses opportunities for practicing collective forms of partnership. This illustrates a problem Jo Freeman identifies with the 'structurelessness' of many feminist organisations. Those who cannot attend meetings and do not sustain close ties with other group members will be excluded from participation. Freeman argues that, furthermore, "those that do not fit what already exists because of class, race, occupation ... etc., will inevitably be discouraged from trying to participate" (1975:51). In my experience, these problems, which are associated with the particular organisational form adopted by the College, affect many regions of the College.

The chairperson from each region is a member of the College's governing

body - the national committee. There are also three consumer representatives, nominated by the consumer group members of the College on the national committee. These consumer representatives come from the Parents Centre Federation, the Home Birth Associations of Aotearoa/ New Zealand, and another position which is usually held by a local maternity consumer coalition group. Their expenses to attend the three two day long meetings annually are paid for by the College. Maternity services consumer groups with established ties to the College include home birth associations, Parents Centre Federation, local maternity action groups and the Auckland Maternity Services Consumer Council, and in some areas, La Leche League and Plunket Committees. Two Nga Maia o Aotearoa me te Waipounamu representatives and two midwifery student representatives are also members of the national committee, as is the national director of the College of Midwives.

Adopting a relationship of partnership with consumers has had important benefits for the College. Liz Tully argues that the rhetoric of partnership was deployed by midwifery leaders to differentiate midwives and midwifery practice from that which is offered by doctors and nurses (1994:53-58; see also Guilliland, 1990:2). Defining a collective identity for midwives as working in partnership with consumers focuses attention on the way in which consumer/ midwife relationships are negotiated, rather than on claims to a separate knowledge base. Highlighting partnership has also enabled College leaders to defuse potential conflicts between midwives with different orientations to childbirth.

The commitment to collective partnership between midwives and consumers has also created conflicts for the New Zealand College of Midwives. Initially many midwives refused to join the College because consumers were included as members of the College and as consumer representatives on key committees. Furthermore, it required rule changes in

the International Confederation of Midwives to allow the New Zealand College of Midwives to retain International Confederation of Midwives' membership. In New Zealand, the College had to negotiate with the Nursing Council of New Zealand in order for them to accept partnership as a cornerstone for midwifery practice (Guilliland and Pairman, 1994:8).

One of the 'standards for practice' set out by the New Zealand College of Midwives is that a midwife annually evaluates her practice through participating in a standards review (1993:22). The standards review committees are interesting because they represent one way that partnership is translated into practice. The domiciliary midwives in Auckland, in conjunction with the Auckland Home Birth Association, established these review committees in 1988 in response to renewed attempts by obstetricians at National Women's Hospital to require domiciliary midwives to be reviewed by the Obstetrics Standards Review Committee.

The significant innovation in this review process was that it was based on consumer and peer review. Half the membership were consumers nominated by the Auckland Home Birth Association, while the professionals included midwives and GPs.¹ Each domiciliary midwife attended one review annually. Over the next years a number of other home birth associations established domiciliary midwives standards review committees (Donley, 1992:a:44-45). In areas where there were few midwives, a committee was constituted for one meeting per year. Joan Donley notes that it was hoped that the review process could eventually "be accorded statutory recognition under the umbrella of the Health Commissioner" (1992a:45). However, these committees have no legal standing.

¹ *Home Birth Newsletter*, June/ September, 1988:13; *Home Birth Whanautanga Newsletter*, No. 43, 1989:11-13.

In 1993 the New Zealand College of Midwives took over the standards review process from the home birth associations and extended them to review domino midwives. The College also standardised the review process. Currently, review committees have four members, two consumers and two midwives. The process is oriented towards support for reflexive practice and self-directed goal setting for improvement and ongoing education for midwives. The standards that midwives are assessed/ assess themselves by focus on partnership, informed choice, high standards of documentation, safe practice and accountability (New Zealand College of Midwives, 1993:15-21). Thus, the review process seeks to encourage midwives to practice in ways that recognise women's right to control over the childbirth experience.

Complicating 'partnerships'

The notion of partnership comes from two distinct sources. The term 'partnership' is associated with Treaty of Waitangi politics. It was 'appropriated' by College midwives from the Māori/ Crown Treaty negotiations pursued by the Labour Government in the second half of the 1980s (Guilliland and Pairman, 1994:8).² This term was grafted on to certain understandings of the ideal midwife/ consumer relationships which came out of the 1980s home birth networks. In using this term, College leaders signalled their intention to address power differences and to work toward non-hierarchical relationships both with respect to consumers/ midwives and Māori midwives/ Pākehā midwives relations (Guilliland and Pairman, 1994:8). Utilising the term 'partnership' highlights some similarities between

² Mason Durie (1998:84-86) notes that 'partnership' was first explicitly used as an interpretive frame in relation to Treaty politics by the Bi-cultural Commission of the Anglican Church, Te Kaupapa Tikanga Rua, 1986, and affirmed by the Royal Commission on Social Policy of which Durie was a member (See Vol. III, 1988:111-126).

these two sets of relationships. At the same time, it obscures the significant differences in what partnership might mean in these two contexts. Attention to these differences provides an interesting way into analysing the complexities of partnership with the New Zealand College of Midwives for home birth activists.

Partnership can be viewed as a complex form of 'equal rights' claim in which 'difference' is made more explicit. Joan Scott argues that the politics of equality in democracies has always assumed, but not articulated differences:

Demands for equality have rested on implicit and usually unrecognised arguments from difference; if individuals or groups were identical or the same there would be no need to ask for equality. Equality might well be defined as a deliberate indifference to specified differences (1990:142).

The notion of partnership is a response to the problem of 'indifference' to difference in equal rights claims. As a relationship between equal but different partners, partnership implies recognition and respect for differences. For example, midwife/ woman partnerships are conceptualised as negotiated, non-hierarchical relationships to which each partner brings her own knowledge, experiences and concerns (Guilliland and Pairman, 1994:14; Strid, 1994:100).

Like demands for equality, partnership in Treaty relations and in the New Zealand College of Midwives assumes the existence of lines of inequalities. These are what these 'partnerships' attempt to address. However, the rhetoric of partnership based on the Treaty has been criticised by some Māori activists, both in the way it has been constructed and put into practice. Mason Durie argues that:

... although partnership implies an association of equals, in

fact it more often refers to a reassignment of government authority to a tribal group within deliberately constrained guidelines (1998:86).

Patricia Maringi Johnston also argues that the government is the 'partner' with more power to define the conditions and the limits of partnership. She further argues, in relation to the Kohanga Reo movement and the Education Department, that the rights of Māori to autonomy and sovereignty are suppressed as Māori are expected to make compromises in the name of partnership:

The Treaty of Waitangi is now seen by Government as the 'founding document' upon which this nation exists. The rights of Maori as Tangata Whenua have been overshadowed by the 'partnership' proffered by the Treaty. This partnership between Maori and Pakeha is defined on Pakeha terms and proceeds only as far as Pakeha will allow it (1994:25).

As I will discuss in the next section of this chapter, home birth activists also articulate critiques of the partnership between the New Zealand College of Midwives and maternity services consumer groups. At the same time, home birth association consumer members of the College, like Māori activists do with respect to the Crown, deploy 'partnership' as a rights frame to ground their political claims. Thus 'partnership' is a resource and a lever for home birth associations, but its realisation is shaped by the professional power of midwives. However, partnership between midwives and consumers connected to the College was forged out of a shared sense of marginalisation in relation to the dominant medical profession. It was seen as a natural alliance among women - midwives and childbearing women. This is a very different history to that of Māori in relation to the Crown, and indicates some of the ways in which Māori/ Pākehā and midwives/ women partnerships might differ.

Within the College most midwifery leaders and consumer representatives are Pākehā. There are critical differences between the partnership between Pākehā midwives and consumer groups and the relationship between the College, with its Pākehā organisational culture, and Māori midwives and consumers. Partnership with consumers grew out of the close ties formed between midwives and groups of birthing women, individually and collectively, in the 1980s. There were no comparable networks for organising for partnership between Pākehā and Māori members. One issue was that there were very few Māori midwives. Also, initiatives to address Treaty partnership in the New Zealand Nurses' Association were in the process of being developed at the time when the Midwives Section reformed into the New Zealand College of Midwives (Doms, 1989; Ramsden, 1995:7; Wood and Schwass, 1993:5). Putting Māori/ Pākehā partnership into practice in the College began to be given serious attention in the mid 1990s as Māori midwives graduated from direct-entry midwifery programmes and a Māori midwives collective associated with the College was established. This collective is called Nga Maia o Aotearoa me te Waipounamu (Fox, 1994; Tully, Daellenbach and Guilliland, 1997:250).

The model for this 'partnership' between women and midwives, individually and collectively, was pioneered by domiciliary midwives and home birth association activists before the formation of the College. Partnership is a reframing of the 'right for women to exercise control in childbirth' that draws attention to the role of the midwife in facilitating this control. Karen Guilliland and Sally Pairman recount that:

Women's need to regain control over their childbirth experience and Midwives' desire to regain independence in practice were complementary. ... The achievements, discussion, information sharing and networking which occurred between women and Midwives in the course of this political activity led to a greater understanding of the relationship between women and Midwives. The

codependent nature of this relationship is personified in the catch phrase 'women need Midwives need women' used by consumer groups and Midwives alike to advertise their partnership (1994:9).

Guilliland and Pairman's definition of partnership between women and midwives emphasises mutuality and interdependence. Home birth activists critiques of 'partnership in practice' within the College, and the demands they make in the name of partnership, seek to enable more equal participation in decision making. This is very different from Johnston's argument that the problems for Māori with Crown partnerships hinge on the way the Crown delimits Māori autonomy through determining the opportunities in which it can be exercised (1994:23-26; see also Henare, 1994:126-127, 134).

While the College's focus on women-centred relationships is consistent with the values of home birth activists, it is potentially in tension with those of the emerging Māori childbirth movement. This woman centredness is the foundation of the College of Midwives' 'code of ethics' and the 'standards of practice'. The code of ethics states that "midwives work in partnership with the woman, midwives accept the right of each woman to control her pregnancy and birthing experience" (New Zealand College of Midwives, 1993:10). Māori health services, in contrast, are 'whānau centred'. Sarah McGee, the kaitiaki midwife for the Nga Maia Te Hauora Paikea Collective in Gisborne, outlines that their organisation seeks to:

... reclaim the traditional birthing practices that Nga Maia or Māori midwives are saying around New Zealand. We need to include whānau, and we are talking about tino rangatirota, the right to their taonga, ... we believe that having the whānau involved in that very wonderful celebration of birth - then he experiences this wonderful event of wairua - the God spirit if you like - and he might be walking on cloud nine for twenty days or more and he is less likely to violate that baby. We don't have any research to say

that is so, but that's what we are working towards (Radio New Zealand, *Insight*, 28 August, 1998).

McGee's comments are indicative of a midwifery practice that is embedded in action directed at broader goals than care for women during pregnancy, birth and postnatally. Men's emotional involvement in birthing is constituted as a resource to enhance family ties, which in turn are seen as an essential resource for Māori self-determination. She argues for a Māori midwifery that attends to the well being of the whānau, rather than just that of the birthing woman and her baby.

Rhetorics of partnership and consumer representation

In the interviews I conducted for this research, a number of home birth activists voiced their concern about the diversity in midwives' interpretations of partnership between consumer groups and the New Zealand College of Midwives. Interview participants suggested that midwives have a variety of different understandings and degrees of commitment to partnership with consumer groups. While some midwives welcome input from home birth associations, others do not view it as relevant or even desirable. This was articulated in the interviews I conducted with the Tauranga, Auckland and Wellington Home Birth Associations, as well as by the two women who have acted as home birth associations' representatives on the national committee of the College. The following discussion between Celia and Marian, both members of the Auckland Home Birth Association, illustrates this point:

- Celia: We have a good relationship with the College, but we have to keep on our toes and keep them on their toes, keep reminding them.
- Marian: Because they do get - some of the midwives, the new

midwives who come along - they don't really know the history of the partnership with women and women's choice.³

Celia: And they have got a kind of vision of them being an organisation like the NZMA [New Zealand Medical Association], like a big powerful organisation for midwives rather than a big powerful organisation for women's choice.

(Auckland Home Birth Association interview, 16 June, 1997)

A similar argument was made by Robyn, who has been a consumer representative of the Home Birth Associations of Aotearoa/ New Zealand on the national committee of the New Zealand College of Midwives:

Robyn: Some midwives think that "women need midwives need women" means "women need midwives need clients", and that's part of why we have to be involved with the College - to keep reminding them about partnership with consumer groups - not just clients.

(Individual interview, 14 December, 1998)

Celia and Robyn argue that as consumer representatives in College forums, they act as 'monitors' to ensure that the discussions among the midwives who attend meetings do not lead to consensus decisions directed at professional self-interest over the interests of birthing women and consumers groups. Marian distinguishes between midwives who "know the history" and those who do not. However, this is also a set of debates over how much significance should be attributed to 'history' in determining present and future courses of action. This debate is illustrated in the following passage. Carol, a midwife from the Tauranga Home Birth

³ I asked whether 'new midwives' referred to those who came from the direct entry midwifery courses. Marian responded that it did not because: "a lot of those women who went into that course have been very active with the home birth associations and other consumer groups before they even became midwives, so they've got a whole history that they are taking into their work with them" (Auckland Home Birth Association interview, 16 June, 1997).

Association, comments on an incident where she tried to persuade a group of midwives to advocate for the inclusion of consumer representation on a committee planning maternity services for the Midland Region. She states that these midwives considered that the history of home birth activism was no longer relevant for the new conditions in the health sector:

Carol (midwife): ... I said "you know it was women who got us here, ... the home birth group worked really hard". And they said "we've got to move on".

Hannah: What does that mean? Does that mean that, yes, the home birth women got us here, or the consumers got us here but, you know, that's history and now we have got to move on? What does that 'got to move on' mean? Does that mean leaving those women behind? Or not having that relationship anymore?

Carol: I think it means all those things.

Hannah: I think it does too, and it's really - it's not the way to go.

Carol: They are becoming business women now.

Tania: What those midwives don't recognise is that the women who were part of getting them there -

Hannah: are part of keeping them there.

(Tauranga Home Birth Association interview, 25 March 1996)

Why is this 'we have got to move on' rhetoric articulated by some midwives so problematic for some home birth activists? In a sense, home birth activists are defending a 'political space' because they feel vulnerable. Home birth activists utilise a certain version of history to justify demands for inclusion in College of Midwives' decision making arenas. The history of the success of the alliance between consumers and midwives in changing childbirth services establishes a claim for the potential power of consumer activism as well as for certain kinds of obligations on the midwifery profession to honour the commitment to partnership.

As a professional body, the New Zealand College of Midwives becomes part of "the network of political, legal and economic institutions that generate legitimating symbols" that underpin professionalisation (Alford,

1975:17). As the more powerful group, the College maintains the prerogative to share power with consumer groups, and in a large part to define how it is to be shared and in what contexts. Robyn, who has represented the Home Birth Associations of Aotearoa/ New Zealand on the national committee of the New Zealand College of Midwives suggested that "maybe the College is the establishment now. I don't know if they really need us anymore" (Individual interview, 14 December, 1998).

Also, partnership is being put into practice in a context where, as a consequence of the health reforms and the neoliberal influence in redesigning social policy, this form of participatory politics is not supported by state policy discourses. At the 1994 New Zealand College of Midwives conference, health activist, Judi Strid argued that:

The restructuring of the health system has played an effective part in undermining the notion of partnership generally. The reforms encourage and reward an individualistic, competitive and entrepreneurial approach. This is usually antagonistic to partnership and can make a women-centred approach difficult to achieve (Strid, 1994:98).

Midwives who disagree with collective consumers/ midwives partnership, or those who take what Dorothy Broom refers to as the "default option of professional privilege" (1990:120) are viewed as a threat by some home birth activists. The position these midwives adopt complicates the ideas that informed the home birth associations' and Save the Midwives' campaign to promote midwives in the 1980s. Many activists assumed that women had pre-given interests in common and that through 'bringing back' midwives, childbearing women would also be empowered. Now some of these midwives, who have regained their right to autonomous practice, constitute their professional interests differently from the ways some consumer activists view women's interests.

However, there is another side to this problem. In several interviews, participants argued that the home birth associations have lost their political strength, and thus, are not in a position to fight for access to political arenas. This was articulated by Jane in an individual interview:

Jane: The home birth associations have collapsed because now home is an accepted place to have your baby - to the extent that hospital-based midwives are offering that service. So women don't have to fight for it anymore. We've achieved what we wanted to achieve and we can celebrate that. But now we don't have that pool of strong, politically minded women that we can put into policy making positions and committees on a national level, and to some extent on regional levels. ... If we had a strong base of women to come from we could fight to have consumers on all those committees, but we don't have that base to fight from.

(Individual interview, 19 February, 1999)

The success of the home birth movement, Jane argues, has resulted in fewer women who feel motivated to participate in home birth activism in political and professional arenas. At the same time as the College is consolidating its position, politically oriented home birth associations and some other maternity consumer groups are losing support.

My experience of being a consumer representative on the national committee illustrated this. During my term, the Maternity Action Alliance, who I 'represented' was reduced to two members. I no longer fitted the definition of a consumer representative that had been adopted by the New Zealand College of Midwives and the Maternity Action Alliance - that a consumer representative has to be selected by a community group and accountable to that group (Coney, 1989:26). However, no other consumer groups at that time were interested in putting forward a replacement and I remained on the national committee until the end of the four year term. I was still involved with the Christchurch Home Birth Association and

networks between home birth associations.

The 'history' of the College of Midwives has been important to home birth consumer representatives in national, and to some extent in regional College forums in another way. Interview participants who had represented home birth associations in the College argued that consumers needed to be "experienced" (Celia, Auckland Home Birth Association interview, 16 June, 1997) because "the issues get so complicated" (Robyn, Individual interview, 14 December, 1998). To effectively participate in the debates that occur in College meetings, consumers need the resources of an institutional memory of past struggles over policy developments in maternity services and networks of other activists engaged in analysing these politics. Jane argues that:

Jane: It's really important that home birth, politically aware home birth is represented. You can't just pick out any person who has had a home birth and say "represent home birth" on National Committee. It's hard enough when you *are* politically aware.

(Individual interview, 19 February, 1999)

Finding 'politically aware' home birth consumers is difficult when the associations do not have a political focus. However this raises another issue. It means that consumer representatives to the College are not likely to be women who have recently birthed. For some College midwives, the ideal consumer representative would be a woman who has had a recent home birth - someone who is a consumer in the sense of actually being engaged in accessing midwifery services. As Tania argues:

Tania: There's a really distinct difference for a lot of midwives between the woman who is due to birth tomorrow and people like me and [others]. ... And in fact comments have been made at times that we're too old, we haven't had babies for a long time, and we aren't entitled to

have an opinion.

(Tauranga Home Birth Association interview, 25 March 1996)

Thus, knowledge of the history of the College and maternity politics is a key resource for consumer representatives. Midwives who argue that the past is not relevant to the present and future, effectively disqualify the basis of long term activists' claims to forms of expertise.

The question of 'who they represent' was another troubling issue for the women I interviewed who had been consumer representatives on the national committee of the New Zealand College of Midwives. There is an expectation that home birth association representatives speak for 'home birth women' or even 'childbearing women'. However, home birth representatives come from local organisations with tenuous links to home birth organisations in other regions. Jane and Robyn both raised this issue in the interviews I conducted with them. Jane argued that "it was really hard not representing a national organisation" (Individual interview, 19 February, 1999), while Robyn stated that: "I represented the home birth associations, but I really only represented my own small group" (Individual interview, 14 December, 1998).

How can a consumer voice be constituted such that it is recognised that consumer representatives are not speaking on behalf of the thousands of women each year who are using the services of midwives? Not only would this require huge resources to do adequately, it is also problematic to suggest that 'birthing women', as a unitary category, can be represented in such a way. Instead, consumer representatives 'represent' the micropolitics of a particular consumer group located within a node of organisational connections. I have argued in this thesis that social movement organisations produce alternative understandings and cultural codes through the face-to-

face interactions among participants. Maybe we need a definition of consumer representation that is informed by an understanding of how such organisations can work, rather than a rhetoric of representing 'women's interests'.

Home birth associations and home birth midwives

One issue that was raised in most of the interview groups was the crucial role midwives played in mobilising support for the local home birth associations. This is illustrated in the following transcript material from the Wellington Home Birth Association group interview:

- Erica: I think there is also a need for the home birth midwives working in that area ... to keep people in contact. Whereas, if someone is just working, just does her job.
- Natalie: In Eastbourne with our midwife is, she comes actually to our meetings - probably one, or maybe one out of every two or three, she'll come along. And people are always very keen to go to it because they might catch a glimpse of the midwife again too. And that's one of the reasons it's so strong and constant.

(Wellington Home Birth Association interview, 25 March 1997)

The interview participants from the Wellington Home Birth Association point out how women who become involved with the association and the support groups have tended to be clients of certain midwives, and not others. Natalie, from the Eastbourne Home Birth Support Group, suggests that as the home birth midwife who works in Eastbourne also comes to the support group meetings from time to time, this offers an incentive for women to join the support group.

The importance of midwives informing and encouraging women to

become part of their local home birth groups was also discussed in the interview I conducted during the 1998 half-yearly meeting of South Island Home Birth Associations.⁴ In this interview, Sara from the Southland Home Birth Association began by talking about how this association was organised. She describes the home birth midwives encouraging women in Southland who planned home births to go to support group meetings. The midwives occasionally attended these meetings as well. Sara maintained that as a result, the Southland Home Birth Association has a large and active membership. The following passage is a conversation amongst the Dunedin participants about their problems with sustaining a support group for women who have had home births and an active home birth association committee. Juliet responds to Sara's earlier comments about the Southland Home Birth Association to account for their different experiences:

- Stella: I think also that the midwives, when home birth was not established, they really needed the home birth associations - they needed each other. They don't anymore as much, so it becomes less of a priority. Because it's an accepted option, they do get paid adequately, they have client caseloads.
- Kate: That's right, but we still rely on our midwives to help us get the information about us out to consumers. And I don't think that's happening as well as it could be, particularly now.
- Michelle: And it's hard for us to tell the women, because theoretically we are not allowed to know who the midwives' clients are, because of client confidentiality. We can't, as a home birth group, access that information and so we rely on our midwives to pass it out to their clients.
- Rea: Yes that's a big change with the Privacy Act.
- Juliet: I think your midwives in Southland - as you said it's more conservative - they probably feel a real benefit from having an association, because it means they can be in contact with people who think along the same lines and have the same philosophy, whereas in their

⁴ For an account of this interview, see appendix I, Dunedin Home Birth Association.

professional contacts with others who work in the hospital they won't get that. And this is to your benefit. Whereas the way things are here is to the benefit of women but it isn't to the advantage of our association because there isn't that feeling. And I think, also, it's the same with women. Women don't feel, here, that if they are choosing a home birth that they are kind of part of this small group that's having to fight for what they want. They can have their home birth.

Denise (midwife): Yes, because its not a limited option in Otago anymore.

Kate: Nearly every midwife is doing home birth. There's only very few who don't offer home birth.

Juliet: So people can have their home birth if they want.

(South Island Regional meeting/ Dunedin Home Birth Association
interview , 25 March, 1998)

Several interesting issues are raised in this discussion which are indicative of changing relationships between midwives and home birth associations since the Nurses Amendment Act, 1990, was passed. Stella argues that before the Act, midwives and women who were engaged in home birthing 'really needed each other'. In many areas of New Zealand, women contacted the home birth associations to find out how to arrange a home birth. At the same time midwives were often members of the associations and joining these groups was a way to support the home birth midwives. The home birth associations developed an organisational form in which 'recruitment' of new members rested on the mutual dependence of midwives and associations on each other. The discussions in these interviews with the Wellington and Dunedin Home Birth Associations suggest that now some home birth associations have become dependent on midwives to link women with the group. At the same time, some midwives no longer perceive a need to have an active role in home birth associations and new midwives are offering home birth who have never had connections to the home birth associations. Members of the Dunedin Home Birth Associations talked about various strategies they had tried to

draw new members. However, none of these had been successful.

Michelle drew attention to how new requirements about client confidentiality have closed down possibilities for home birth association members to approach women who are planning home births directly. The other side of the woman/ midwife partnership, as a relationship between the individual midwife and birthing woman, has been exacerbated by the Privacy Act, 1993, which has meant that midwives can not pass on lists of their clients to the association members without these client's explicit consent. This places midwives in a more crucial position for connecting birthing women to their local home birth group.

Juliet suggests that the marginalisation of home birth midwives in 'conservative' rural Southland contributes to maintaining a strong home birth association because these midwives still need the support of close connections with consumers of home birth services. However, the case of the Eastbourne Support Group, where the midwife and women who are interested in home birth are not marginalised, illustrates that the orientation of particular midwives towards supporting home birth groups can have a strong influence. In Dunedin, on the other hand, home birth has come to be seen as mainstream and is part of the repertoire of services offered by 'nearly every' independent midwife working around Dunedin. Paradoxically, support for the association from midwives and consumers choosing to birth at home has fallen.

The difficulties faced by home birth associations in attracting new members highlights another set of the complexities surrounding 'partnership'. The model of partnership promoted by the New Zealand College of Midwives focuses on the partnership between the individual midwife and the birthing woman, or, on the partnership at the level of the organisation of the College itself. What tends to be left out of this framing of partnership is the

relationship between individual midwives and consumer groups. This is the nexus of partnership which sustains home birth groups. Their membership relies on those midwives who are prepared to facilitate women attending home birth meetings. This is particularly problematic for associations who have support groups as part of the services they offer.

A number of home birth associations offer antenatal classes and/or postnatal home help which gives them alternative opportunities to invite or encourage women to come to home birth meetings. However, these home birth associations may still rely primarily on midwives to provide the information about these services to pregnant women who are planning to birth at home. One example of this emerged in the second interview I conducted with members from the Tauranga Home Birth Association. Tania told of hearing about women having home births who had not known about the postnatal home help services for home births, which were provided free of charge under a contract between the Tauranga Home Birth Association and the Midland Regional Health Authority (13 June, 1997). In Tauranga all GPs withdrew from providing maternity care after the Section 51 payment mechanism, which replaced the maternity benefit schedule, came into effect. It was, thus, some midwives who attended these home births who failed to inform these women of their entitlements.

The Manawatu Home Birth Association interview participants, by contrast to the other groups, were not faced with the problem of dependence on midwives to generate support for their group. This association is in a unique position because they successfully negotiated a contract with the Central Regional Health Authority to provide a complete home birth service. This contract covers premises, a part-time paid coordinator, antenatal education, postnatal home help and nappy service and midwifery and/or GP care through the entire pregnancy, birth and postnatal period for women planning to birth at home. The contract is administered through a

trust board called Community Birth Services (CBS) made up of home birth consumers, midwives and a GP. This helps to maintain close ties between midwives and home birth association consumer members and also gives them a higher profile in the community.

A past member of the Christchurch Home Birth Association comments that the decline of support networks among women who have home births produces changes in the relationships between midwives and birthing women:

Tilda: We had such a sense of working together, woman and a midwife on the same side. Take tradespeople - you don't think they are on your side - you watch them - contract them. We were working together. But being part of a group gave you a sense of that. Now I think its different. It's a more individual thing - not so much working with the midwives and being part of a group. What we are doing now is individualising the experience - in a way replicating hospitals.

(Individual interview, Christchurch, 31 May, 1998)

'Being part of a group' Tilda suggests help from solidarity ties between women and midwives. Now that women no longer make connections to the home birth associations in such numbers, she suggests, women are becoming more critical of the midwifery care they receive. Perhaps there are still ways in which home birth midwives might still benefit from being involved in home birth associations.

Conclusion

In this chapter I have argued that the rhetoric of partnership came out of the joint activism by a group of midwives and their consumer supporters in the

1980s. This was based on the notion that 'women need midwives need women', that is, that the interests of midwives and childbearing women coincide. The realisations that this might not always be the case creates conflicts for contemporary home birth activists. Leaders of the New Zealand College of Midwives utilised the term 'partnership' to describe this relationship between midwives and birthing women and simultaneously signal their organisational commitment to recognising the Treaty of Waitangi.

I argue that there are, however, significant differences between these two sets of politics. While Māori seek to regain their right to self-determination and 'difference', home birth activists within the College of Midwives aim to secure agreement on mutual goals. Nonetheless, both groups can utilise the stated commitment to partnership by the more powerful partner as leverage for furthering their political interests. I suggest that the professionalisation of midwifery through the efforts of the New Zealand College of Midwives poses new challenges in defining the roles and identities of consumer representatives. This takes on a greater urgency in the light of the loss of political focus in the home birth movement.

9

Negotiating contractual identities

Contract has become an inescapable feature of contemporary public life. The language and practice of contract is now applied to the management of a diverse range of problems in public administration, employment, schooling, the ordering of marriage and marriage-type relations and minority rights. In the public sector the possibility of a virtual government - networks of private suppliers, linked by contracts to a small residual state - seems ever more plausible.

Davis, Sullivan and Yeatman (1997:viii)

Introduction

The restructuring of the health system over the past decade has made it possible for home birth associations to tender for contracts with health funding agencies. These contracts range from providing specific services for women/ families planning to birth at home, such as antenatal classes, postnatal home help and/ or nappy services, to coordinating a complete home birth service, which includes midwifery care. Thus, home birth associations, which began as submerged networks where women shared their experiences of home birth, and became political advocates for a marginalised birthing option in the 1980s, can now potentially be providers of government funded services for women birthing at home.

Many associations have not been interested in contracting, either because it requires commitment and skills which they do not have, or because of an ideological disagreement with contractualism itself. For those associations who have put together tenders for some form of contract, success has been mixed. Home birth groups in some areas have negotiated contracts with a regional health authority or the Health Funding Authority, while others have not. These differences offer an excellent research opportunity to explore some of the complexities and the dilemmas around contracting for home birth association activists.

The use of contracts to reformulate social policy frameworks has become fashionable among the political elites of a number of Western nations over the last decade, driven largely by the influence of neoliberal and neoclassical economic paradigms (Dalziel and St John, 1999:87; Goldfinch, 1998; Wallis, 1997). In Britain, the Netherlands, Sweden and New Zealand, purchaser/ provider splits or 'quasi-markets', which rely on the use of contracts, have been introduced into the national health systems (Ashton, 1999:135; Flynn, Williams and Pickard, 1996:1; Jacobs, 1998). In New Zealand this involved establishing four regional health authorities in 1993 as purchasing agents for the health services that New Zealanders required - or expected to be provided - through the government's health budget. These regional health authorities were amalgamated into one Health Funding Authority in January, 1998, following the coalition agreement between the National and New Zealand First parties. This happened after most of the interviews I conducted for this thesis.

With the institution of the purchaser/ provider split in the early 1990s, the responsibility of paying for primary maternity services was transferred from the Department of Health to the regional health authorities. Thereafter, midwives and GPs could claim fees through a contract with the health authority responsible for purchasing services in the region where they

practiced, or they could be paid under a direct local contract between a health funding agency and a provider organisation (Performance Management Unit, Ministry of Health, 1998:50-55).¹ Such provider organisations include public hospital based providers (such as a Crown health enterprise (CHE) before 1998 or a hospital and health service (HHS) since then), private hospitals, groups of health professionals, iwi or marae based groups and other community groups. It is within this context that some home birth associations have sought to become providers of home birth services.

A number of home birth associations have at one time or another attempted to negotiate contracts with a regional health authority or the Health Funding Authority. The Auckland, Tauranga, Waikato,² Manawatu and Wellington Home Birth Associations have all put together tenders for contracts to provide a complete home birth service, including midwifery care. Of these, only the Manawatu and Auckland Home Birth Associations contracts have been successful, the first in 1995 and the second in 1999. The Waikato,³ and Southland Home Birth Associations have tried to tender to provide

¹ Midwives claimed off the maternity benefit schedule until the 1 July, 1996. This was an uncapped fee-for-service payment schedule. After this, midwives could be reimbursed through Section 51 of the Health and Disability Act, 1993. This is a capped fee that is claimed under several modules.

² Aotearoa/ New Zealand Home Birth Associations conference, Gore, 1993, personal notes.

³ Aotearoa/ New Zealand Home Birth Associations conference minutes, Christchurch, 1996. The Waikato Home Birth Association put together a tender in response to a notice by the Joint Regional Health Authorities Maternity Project which was sent out to interested parties early in 1996. It promised that 'help at home' services would be funded "for women who have their babies at home or leave hospital within a specified time after the birth. The RHAs see this as an important service for women and a means of helping make sure that women and babies stay happy and healthy after the birth" (1996:5). This service was subsequently dropped from the July, 1996 Section 51 Notice. The introduction of 'targeted help at home' following childbirth has been included in the *Funding Agreement between the Minister of Health and the Health Funding Authority for the Period: 1 July, 1999 to 30 June, 2000* (New Zealand Government/ Health Funding Authority, 1999:99).

postnatal home help for home birth families, but only the Tauranga Home Birth Association has held a contract to provide this service. In 1995 the regional health authorities decided to purchase antenatal classes separately from Section 51, and the Waikato,⁴ Taranaki,⁵ Christchurch and Dunedin Home Birth Associations were given contracts for antenatal classes. This chapter focuses on the Auckland, Manawatu and Tauranga Home Birth Associations to examine several sets of issues related to contracting to provide a complete home birth service.

It is important to note that a number of these contracts are not formally held by the entity of the home birth association. Rather associations set up separate trusts, such that the finances of the contract are completely separate from those of the association. These trusts are specifically created for the purpose of providing the services purchased by a health authority. For example, members of the Manawatu Home Birth Association established a provider trust called 'Community Birth Services Trust'. The Tauranga Home Birth Association tendered for a contract to provide a full home birth service under 'Trust Home Birth Tauranga' and the Christchurch home birth antenatal classes contract is held by the 'Home Birth Classes Christchurch Trust'. At the time of the interview, members of the Auckland Home Birth Association had not yet found a name for their trust.

When participants talked about these contracts in the interviews they tended to gloss over the distinction between these separate legal entities, except in the interview with the Manawatu Home Birth Association. Even here, participants who were not trust board members demonstrated a sense of ownership over Community Birth Services - using the word 'we' to refer to

⁴ *Waikato Home Birth Association Newsmagazine*, August, 1998:9-10.

⁵ *Taranaki Homebirth Newsletter*, Spring, 1998:2-3. This contract was not renewed in 1999 (Aotearoa/ New Zealand Home Birth Associations conference, regional reports, Dunedin, Gore).

activities of the trust - which is indicative of a blurring of the boundaries between the Manawatu Home Birth Association and Community Birth Services. A key difference between the associations and the trusts is that 'membership' of all home birth associations' committees is open to anyone who is interested and people who come along to meetings can do as much or as little as they like.⁶ Members of a trust board, by contrast, are nominated or coopted and have statutory responsibilities. Trustees of home birth association contracting projects are thought of as 'representatives' - consumer representatives of the association or representatives of the midwives who work with the Trust, and the Community Birth Services Trust includes a Māori representative (see for example, Griffin and Walsh-Tapiata, 1998:36-37).

This chapter and the one following examine three interconnected sets of questions. In this chapter I discuss the issues surrounding the discourses that different home birth association core group members invoke, resist and rework in crafting their positions or identities in relation to contracting. Chapter ten explores the new challenges for home birth trust boards posed by entering into a contractual relationship with a statutory agency. It also addresses the question initially raised in this chapter: does contracting offer a new way of 'doing' politics or is it antithetical to a political role for home birth associations?

The new contractualism - theoretical debates

The possibility of providing home birth services through government grants to home birth associations was first raised in a report produced in

⁶ See chapter six for a discussion of the organisational structure of home birth associations in New Zealand.

1987 by Jennie Nicol, an advisory officer from the Department of Health. This option, Nicol notes, "generated some interest" among the home birth midwives and the members of home birth associations whom she spoke to (1987:16). However, the home birth activists consulted by Nicol advocated maintaining the 'status quo' where domiciliary midwives were paid by the Department of Health. They felt that funding a home birth service through grants would be insecure because:

... grants could be reduced or not be reallocated at the whim of political expediency, and that such a 'grace and favour' system would divest the department of its responsibility towards provision of the service (Nicol, 1987:16).

As I outlined in chapter five, home birth movement activists in the 1980s framed their claims around 'home birth as a right' that needed to be guaranteed by the state. In their assessment of the political opportunity structure, this was best achieved by keeping domiciliary midwives' contracts under the jurisdiction of the central government agency, the Department of Health.

Nicol notes that home birth activists rejected the grant scheme because, they argued, if home birth associations were adequately reimbursed for their administrative work, this would introduce a new tier of bureaucracy that "would be a waste of money and not cost effective" (Nicol, 1987:16). Activists were also concerned that through a grant, they might end up doing this work for little or no financial recompense and thereby tacitly support an undesirable government trend of extracting more unpaid welfare work from women (Nicol, 1987:16).⁷

⁷ This trend in government policies was identified and critiqued by Carole Pateman with respect to the Thatcher and Reagan Governments' policies (1989:192) and in New Zealand, by Anne Else (1992:240-244) and Phillida Bunkle and Jo Lynch (1992:37-38).

These objections by some home birth associations to becoming home birth service providers are interesting in light of decisions to tender for contracts a few years later. How did this shift occur? Firstly, as I discuss in this chapter, it took place in different ways among those groups who became interested in contracting. These differences are important because they have implications for how each group constructs a collective identity as a potential provider. We also need to attend to the implications of restructuring the health system along contractualist lines. However, conflicting theoretical appraisals of the shift to contractualism and the diversity in the practices of contracting out health services reveal more contradictions and paradoxes than straightforward conclusions. It is these contradictions and paradoxes that home birth activists must negotiate in their engagement with, or rejection of, contracts to deliver home birth services.

Garth Nowland-Foreman, who has conducted research on the impact of the new contractualism for voluntary organisations in New Zealand contends that:

The government's purpose in replacing grant-in-aid with contracting in Aotearoa/ New Zealand was to achieve greater accountability of voluntary organizations to government; more competition among service providers to ensure increased efficiency; more freedom for the government to switch funds ... to ensure compliance with government requirements; more choice for clients among different services; and the growth of specific services tailored to meet the needs of specific groups (1998:115).⁸

He suggests that contracts have increasingly replaced grant funding for voluntary organisations in New Zealand over the last decade. This, in his view is part of a governmental effort to integrate the work of voluntary agencies with the government's social welfare objectives. Nowland-

⁸ This is paraphrased from Shipley, Minister of Social Welfare (1991:77).

Foreman argues that while this may provide more opportunities for community groups to deliver services, it also brings them under more direct forms of statutory surveillance (1998:114-116; see also Higgins, 1997:3-6).

Paul Dalziel and Susan St John argue that two economic theories underpin the increasing interest in contracts. These are 'competitive market theory' and 'agency theory', or 'principal-agent theory' (1999:87). Simon Upton summarises market theory as follows: "the market order provides for the efficient allocation of resources" on the "basis of performance rather than status", "defuses the potential for social conflict" and ensures ongoing innovation (1987:7-9). Agency theory suggests that employment and funding relationships should be conceptualised as relations of exchange in which contracts offer a mechanism to "align an agent's incentive to perform certain tasks with the preferences of the principal" in return for some specified reward (Dalziel and St John, 1999:87; see also Althaus, 1997:137, 141-142; Scott, 1997:162). Catherine Althaus argues that agency theory relies on competitive markets to ensure that principals and agents have freedom of choice in entering into contracts and that agents will seek the most efficient ways to deliver the outputs that the principals require (1997:148-149; see also Dalziel and St John, 1999:87).

What happens when agency theory is applied to the public sector where there are only limited internal markets? Can contracts still work to secure cooperative mutually beneficial relationships? Or, when the principal is the state, do contracts become coercive devices, "a convenient way to repackage older notions of mandate" (Davis, 1997:227)?⁹ Alternately, does

⁹ The designers of the 1991 health reforms were aware of this problem and sought to address it with legislation to open competition for non-governmental health service purchasers - health care plans (1991:65-67). This has since been shelved due to a lack of solutions to the problems of risk assessment and risk management (Ashton, 1999:137).

contracting out services by statutory authorities open spaces for new forms of political claims? I will argue that contracting can do all these. While the inspiration for restructuring the public sector along contractualist lines may have come from agency and market theories, other groups can attach various different meanings to the practices of contracting, and contractualism itself can become subject to political struggles.

Glynn Davis, Barbara Sullivan and Anna Yeatman make the argument that contractualism represents a 'new mode of governance' whereby government can be achieved through "a cascade of contracts" (1997:5; see also Davis, 1997:236; Hindess, 1997:23-26). The structure of the current maternity services in New Zealand are an excellent example of a cascade of contracts, which includes the contract between the Minister of Health and the regional health authorities, now the Health Funding Authority, who in turn enter into contracts with a variety of maternity service providers, some of which include further contracts, for instance a home birth association contracting midwives to attend home births. Under Section 51, which includes the specifications for primary care maternity services, each birthing woman is expected to nominate a 'lead maternity carer' (Joint Regional Health Authorities Maternity Project, 1996). Thus, the birthing woman and her lead maternity carer also enter into a contract.

According to liberal economic theory, this 'cascade of contracts' is not a repackaging of bureaucracy that crosses over from the state into the private sector, because contractual relationships are seen as different from the hierarchical status relationships that characterise bureaucratic forms of control (Duncan, 1997:63). In this discourse, a contract is seen as an instrument for defining and recording a mutually agreed upon relationship of reciprocal obligations and benefits between two or more parties. Contracting assumes that the parties enter into it freely and coercion is seen as invalidating the contract. Therefore, unlike status based relationships,

contracting parties are considered to have formal equality (Sullivan, 1997:7; Yeatman, 1997:39-42).

I will argue that this 'formal equality' is problematic for home birth trusts that want to enter into contract negotiations. It is perhaps this promise of formal equality which makes contracts more attractive than grants for some home birth activists. At the same time, as small local groups of mothers, they are disadvantaged relative to professional and business providers. They must prove their contractual capacity in order to be recognised as potential providers by the authorities from which they are seeking a contract. The ways in which different home birth groups engage in claiming contractual capacity brings to light how liberal conceptions of contract are predicated on certain status assumptions which can exclude some groups from participating in a contractual society. This, Yeatman argues, opens opportunities for challenging collective action on the part of marginalised groups to politicise contractualism by demanding the information and resources necessary to ensure their equality of contractual standing (1997:52-54).

The notion of contracts resonates with a key aspect of the home birth associations' collective action frame - their reconceptualisation of the ideal relationship between a birthing woman and her midwife. The emergent practices within home birth networks and the lobbying by home birth activists in the 1980s were directed at creating alternatives to the hierarchical power relationships inherent in masculinist forms of professionalism. As I argue in chapter six, home birth activists claimed, on behalf of all birthing women, that women have the capacity to make decisions about childbirth and that the midwife's role is to provide a woman with support and information to make the decisions that are right for her. This conception of the relationship between midwives and birthing women, that later came to be named 'partnership', can be viewed as a

contract.

Sullivan suggests that the new contractualism can be interpreted as enhancing the opportunities for individuals or community networks to "participate in their own government" or to exercise forms of self-determination within civil society (1997:5, 9; see also; Hindess, 1997:24-25; Yeatman, 1997:51-54). Alternately, contractualism can be seen as a new technology of governmentality that produces certain kinds of subjects who, through 'self-regulation', can be mobilised to serve social and political objectives (Sullivan, 1997:9; see also; Davis, 1997:236-237; Miller and Rose, 1990:24-28; Stoker, 1998:17-18). This debate hinges on the question of whether these networks of contractual relationships operate as an "identity politics heaven", or as a "dispersed panopticon" (Fougere, personal communication, December 1997). It is these alternative possibilities and contradictory effects which both shape and are shaped by the ways in which community groups engage in contractualist relationships with state agencies.

Tauranga Home Birth Association

The Tauranga Home Birth Association was the first home birth association in New Zealand to have a 'contract' to provide aspects of home birth services. The idea of 'contracting' was initiated by the Western Health District of the Bay of Plenty Area Health Board, who held a public meeting in October, 1990, to explore possibilities "for joint ventures between hospital services and community groups" (*Tauranga Home Birth Association Newsletter*, October, 1990:2). Subsequently, some members of the Tauranga Home Birth Association put together a successful application to Western Health District of the Bay of Plenty Area Health Board to pay for

a midwife's equipment for home birth. This included an oxygen cylinder and regulator, a sonic aid and a telepager. In a meeting between members of the Tauranga Home Birth Association and managers of the Bay of Plenty Area Health Board to discuss this application it became a "contract between the two parties", although it was perhaps more accurately a 'grant' (*Tauranga Home Birth Association Newsletter*, December, 1990:1).

After the announcement of the provider/ purchaser split in the health sector, the Bay of Plenty Area Health Board initiated another community health project. They sought proposals to develop 'model' contracts with community groups that could be adopted when the regional health authorities took over (Tauranga Home Birth Association, 1994:149). The Tauranga Home Birth Association submitted a proposal and in August 1992, they were awarded a contract with the Bay of Plenty Area Health Board to provide free (to the user) antenatal workshops, postnatal home help and a nappy service for women intending to birth at home in the Tauranga area. These services were not funded by Area Health Boards for home births anywhere else in New Zealand. The contract also covered publicity for these services and wages for two part time employees to 'coordinate' the contract (*National Network Newsletter*, October, 1992:2-3; Matthews, Stewart and Sharplin, 1992:5). The coordinators met each woman antenatally to inform her of the services available. The contract was capped at a specified amount annually, which was at times problematic when demand was higher than expected (Tauranga Home Birth Association interview, 25 March, 1996).

This contract was set up with the intention that, in the future, the Tauranga Home Birth Association could provide a complete home birth service, which would include paying midwives for the antenatal, labour, birth and postnatal care of women planning a home birth, as well as antenatal workshops, postnatal home help and a nappy service (Matthews, Stewart

and Sharplin, 1992:4-5). The Tauranga Home Birth Association contracting group and the Bay of Plenty Area Health Board agreed to a smaller contract to allow both parties to build up knowledge and skills in tendering and managing a contract for community health services (Matthews, Stewart and Sharplin, 1992:5). As sociologists Rob Flynn, Gareth Williams and Susan Pickard demonstrate in their study of community health services contracting in Britain, translating the work done in community health services into contract specifications often proves difficult and contentious (1996:22-41).

Tauranga Home birth activists believed that as well as seeking to develop technical instruments for purchasing community health services, the maternity services manager of the Bay of Plenty Area Health Board was interested in reducing the caesarian section rates at the Tauranga Maternity Annex.¹⁰ By making home birth more attractive to birthing women, and repositioning the Tauranga Home Birth Association as a provider group, Tauranga Home Birth activists argued, the maternity services manager hoped to be able to exert pressure on the specialist obstetricians at the Annex to change their practice (Tauranga Home Birth Association, 1994:149; Tauranga Home Birth Association interview, 25 March, 1996). This illustrates that contracting out can be utilised in the health sector as a way to challenge professional monopoly. At the same time, Nancy North points out that it can also open new opportunities for professional monopolists to exercise more control in configuring and delivering health services, which she suggests is occurring in Britain with respect to the general practitioner fund holding schemes (1995:123-125).

¹⁰ This was in line with the performance indicators being developed for the area health boards by the Department of Health. These included a proposal to reduce caesarian section rates to the level recommended by the World Health Organisation of less than 10% of births as an performance target for area health boards (Dahl, 1990:11; World Health Organization, 1985:2). This is because the morbidity rates for caesarians are higher than for normal vaginal deliveries as well as incurring significantly higher costs. The Performance Management Unit of the Ministry of Health found that the cost of caesarians is 1.6 to 2 times the cost of a vaginal birth (1997:78-79; 1998:58-59).

The Bay of Plenty Area Health Board required contract proposals to demonstrate cultural appropriateness and recognition of Treaty of Waitangi obligations. This prompted the members to contact two Māori independent midwives and Māori women who had birthed at home. After several meetings, a Māori home birth group, called Te Aruhu Mōwai, was formed. This was a parallel service for and by Māori women, covered by a separate payment under the contract between the Area Health Board and the Tauranga Home Birth Association (Matthews, Stewart and Sharplin, 1992:5-6; *New Zealand College of Midwives, National Newsletter*, December, 1995:50). Relations between members of Te Aruhu Mōwai and members of the Tauranga Home Birth Association core group became strained and communication ceased between the two groups in 1994. Te Aruhu Mōwai decided to disband in 1996 (Tauranga Home Birth Association interview, 13 June, 1997).

In the first interview I conducted with members of the Tauranga Home Birth Association, Hannah explained why they considered that it was important for them to contract to provide services to women birthing at home. She read out from, and commented on a presentation made by her group at the 1994 New Zealand College of Midwives conference:

Hannah: You asked why it is a Home Birth Association should provide services to women who birth at home. And I'll just read this: "The Tauranga Home Birth Association story is an example of a maternity service being provided for consumers of maternity services by the organisation which represents the consumers of that very same maternity service. So, in other words, it is a service provided by those who use it." And I think that's really important, that if there is going to be a service provided to women who birth at home, it needs to be provided by the women who use it, because they know what they need. "Who else is better placed, has the knowledge and has the expertise to provide a home birth service to consumers than a

home birth association?"

(Tauranga Home Birth Association interview, 25 March. 1996)

Hannah and the women who wrote the speech argue that home birth associations are the best providers of home birth services because as women who use, or have used the service, the association knows what women need. This assertion draws on the 'standpoint' position of the women's health movement that validates the knowledge women have about their own lives and the knowledges generated by the participants of grass-roots community groups (Bunkle, 1992:64-65; Coney, 1989:25-26). Sandra Coney, a feminist health activist from Auckland, uses this argument to justify the inclusion of consumer representatives in health policy making and monitoring forums. She stresses that consumer representatives need to be actively engaged in a 'collective self help' consumer advocacy group (1989:26). Hannah extends this to argue for contracts between consumer groups and statutory authorities to provide health services in the community.

When the Midland Regional Health Authority replaced the Bay of Plenty Area Health Board in July 1993, the Tauranga Home Birth Association postnatal services contract was 'rolled over'. In 1994, members of the Tauranga Home Birth Association put in a tender to the Midland Regional Health Authority for a contract to provide a complete home birth service (Tauranga Home Birth Association, 1994:148). For a number of reasons negotiations continually stalled and in November, 1997, the Tauranga Home Birth Association contract to provide antenatal classes and postnatal home help for home birth families was discontinued.

In the interview, Hannah and Tania contended that there was a fundamental shift in the approaches to contracting followed by the Bay of Plenty Area Health Board and the subsequent Midland Regional Health Authority.

- Hannah: They [the Regional Health Authority] don't have a concept of a 'community group', what a 'community group' is. They call us a 'provider group' and they treat us like we should be bristling with shoulder pads ... whereas we have no money to be like that.
- Tania: They have no concept of how we run, absolutely none - even as people - and as a community group, because they come from that background of shoulder pads and plenty of bucks. ...
- Hannah: So they don't give us the attention, we always get put to the bottom of the pile. ... With the Area Health Board, it was to our advantage to be barefoot and have hole-ly clothes and be a bunch of mothers. That was our biggest asset.

(Tauranga Home Birth Association interview, 13 June, 1997)

Hannah and Tania invoke a metaphor of 'dress codes' to express their perceptions of the differences between a community and a market approach to contracting. They construct being "barefoot" and wearing "hole-ly clothes" as signifying their association's grass roots community group status, as opposed to the "shoulder pads" which mark a business oriented "provider group".¹¹ They suggest that their community group status, that was an advantage with the area health board, ceased to work in their favour with the Midland Regional Health Authority. They argue that the managers for the contract did not have an understanding of their personal and collective lack of resources.

Participants in the interview group comment that they were not able to negotiate funding to buy a computer and accounting programmes. Therefore:

Alison: We always put the reports through in writing in long

¹¹ I think it is interesting that they use "shoulder pads" rather than 'suits and ties' to refer to the contracting managers. This suggests that the regional health authority managers they interacted with were women.

hand - to show them what we don't have. [Name] types up invoices, but on her own typewriter so each one is different.

(Tauranga Home Birth Association interview, 13 June, 1997)

In a discussion about the social practices associated with contracting, Hannah gives an example that graphically illustrates their disadvantaged position vis-à-vis other providers:

Hannah: Going to business meetings with GPs and stuff [health authority managers?] that will turn up in their Mercedes Benzes and their Porsches, and we have to take our own lunch because we can't afford the lunches.

(Tauranga Home Birth Association interview, 25 March, 1996)

In the case of the Tauranga Home Birth Association, the intensification of contractualism in New Zealand was *not* associated with opportunities to enter into contractual relationships with those distributing funds. They lost their contract because they could not 'fit' the corporate model of who might be trusted with a contractual relationship.

Manawatu and Auckland Home Birth Associations

The Auckland Home Birth Association made their first application for a contract in response to a call for tenders for pilot projects. The Health Reforms Directorate and the Health Department were interested in gaining experience to develop technologies in contracting for personal health services (Auckland Home Birth Association interview, 16 June, 1997; Health Reforms Directorate & Department of Health, 1992).¹² The Auckland Home

¹² The Health Reforms Directorate had the responsibility for establishing the four regional health authorities as purchasing agents. These projects were undertaken to gather information and develop skills in different kinds of

Birth Association application was not successful, but this document provided the basis for their future contract negotiations with the Northern Regional Health Authority. These were still ongoing at the time I conducted the interview with the Auckland Home Birth Association (Auckland Home Birth Association interview, 16 June, 1997). Since then, in June, 1999, they have reached an agreement on a contract with the Health Funding Authority.

Celia recounted that members of the Auckland Home Birth Association decided to tender for a contract to provide home birth services to test the rhetoric of health sector administrators who promised that the reforms would benefit community organisations. In the 'green and white' paper outlining the proposed health reforms, Upton argues that:

One of the benefits from separating purchasers from providers is more opportunities for voluntary groups to bid for funding to provide services. This will in turn result in the provision of more appropriate services to many groups in society (Upton, 1991:123).

Celia also frames engaging in contracting as one possible strategy in a struggle to ensure some measure of consumer control of home birth. It is seen as a new means by which old adversaries could potentially exercise control over home birth services. Celia argued that:

Celia: One of the planks that Simon Upton sold the health reforms on was consumers having more and more [inaudible word/s - input?] in planning and provision in health care. And so we thought "well, we'll take you up on this". Also because home birth was becoming a more mainstream option, we were really concerned that other health providers that were more institutionally based would nominally take over the home birth option and strangle it, basically - that they would put so many restrictions on it that it wouldn't be

contractual arrangements with primary care providers (Health Reforms Directorate & Department of Health, 1992).

accessible to women or midwives - other people putting conditions on who could have home births and how it would be provided.

(Auckland Home Birth Association interview, 16 June, 1997)

Participants from the Manawatu Home Birth Association interview group also viewed contracting as a strategy for securing their position as advocates for home birth in the face of uncertainty over the future of home birth services:

Judith: It started with the health changes and basically it started with the fear that -

Christina: that we were going to lose home birth.

Judith: And so rather than hang around and wait, ... members of the home birth association decided to be proactive.

(Manawatu Home Birth Association interview, 24 March, 1997)

Not only were there no guarantees of continued state funding for home birth in the restructured health system,¹³ the introduction of competitive tendering opened up new possibilities for 'institutionally based' and medically oriented providers such as publicly owned hospitals or independent practitioner associations (groups of GPs) to include home birth in their service contracts.¹⁴

Groups of midwives and midwifery provider organisations are another potential source of competition. Many home birth activists have divided loyalties with respect to 'midwives' collectively. As I discussed in the previous two chapters, home birth activists are caught between their investment in partnership and a critical stance towards domino midwifery.

¹³ In the interviews, several areas where it was difficult to access home birth services were mentioned (Dunedin Home Birth Association interview, 25 March, 1998; Tauranga Home Birth Association interview, 13 June, 1998).

¹⁴ A few CHE or HHS organisations have begun offering home births, but this has occurred after I conducted the interviews for this research.

This leads to ambivalences about backing such schemes. Also, home birth activists commented in interviews that midwives who were most likely to be interested in establishing businesses were also less likely to be committed to 'collective' partnership between midwives and consumers groups (Auckland Home Birth Association interview, 16 June, 1997; Tauranga Home Birth Association interview, 25 March, 1996).

These new possibilities are indicative of the success of home birth activism in remaking home birth as a more accepted birthing option. However, the interview participants from the Auckland and Manawatu Home Birth Associations express concern that if hospital birth oriented groups are contracted to provide home birth services, they will employ medical definitions and criteria to select which women are 'eligible' for a home birth. It is this *limited* acceptance of the home birth option on the part of mainstream maternity professionals that activists view as a threat to the availability of home birth services.

Jeffrey Weeks and Peter Aggleton outline a similar problem for voluntary agencies working in the HIV/ AIDS field in Britain. Like the home birth associations, these groups, in conjunction with sympathetic health professionals designed and delivered collective self-help services to communities at risk before there was any institutional response to the new epidemic (1996:107). The success of these initiatives now makes them attractive to mainstream providers who want to seek more funding by expanding their services. Weeks and Aggleton point out that this has contradictory effects. It reconstitutes HIV/ AIDS "as a problem that the whole community has to face" but at the same time may "marginalize or endanger the specialist [voluntary community] HIV services that have developed" (1996:119). Furthermore, they argue that when these services become part of generalist, mainstream agencies, they may be provided by health professionals who do not have special expertise in this area and may

not even ideologically/ philosophically support the service (1996:119-120).

Another issue for home birth associations in New Zealand interested in contracts and HIV/ AIDS community projects in Britain is that 'quasi markets' can be introduced into the health system with different ways of balancing the dual imperatives of statutory monitoring and control and allowing market forces to operate.¹⁵ When the New Zealand health reforms were initially outlined, Simon Upton, the Minister of Health argued that the changes would increase choices for consumers, implying that eventually a range of services offering the same 'output', but tailored to meet different consumer preferences, could be purchased from competing providers (1991:35, 37). Alternately, the 'competition' between providers can be concentrated in the tendering process, with one provider being given the contract to provide certain services for the whole population of an area. In this model, service providers compete for funding rather than for clients (McGuire, 1997:116). Contracting with one, rather than several providers may be more cost-effective for purchasing agencies because it reduces transaction costs - the costs associated with negotiating, administration and monitoring of contracts. However, it places specialist community groups at a disadvantage in attracting funding relative to providers who can offer a broader range of services.

When the regional health authorities formed a joint working party in 1994 to negotiate with representatives from the New Zealand College of Midwives and the New Zealand Medical Association on a payment schedule for health professionals providing primary care maternity services, the concern

¹⁵ This point is made by Alan Jacobs in his comparative study of the introduction of quasi markets in various European nations. He argues that: "Hiding behind the word purchaser are ... different kinds of financiers vested with very different powers and responsibilities Similarly with the word consumers, who in one context merely choose the site of care, in another choose and pay for the consequences of their choices and elsewhere passively consume what the state purchases" (1998:29).

that one mainstream provider could be contracted to deliver all home birth services for a particular area was somewhat allayed (Auckland Home Birth Association interview, 16 June, 1997). This schedule established a direct payment mechanism for midwives, such that they would not be forced to work under a contract with a provider organisation. During these negotiations, which took more than two years, the Northern and Midland Regional Health Authorities were unwilling to finalise contracts with the Auckland and Tauranga Home Birth Associations. The Central Regional Health Authority maternity manager, with whom the Manawatu Home Birth Association negotiated, was more interested in direct local contracts.¹⁶

The Manawatu Home Birth Association, based in Palmerston North, was the first home birth association in New Zealand to hold a contract with a regional health authority to provide a complete home birth service. Members of the Manawatu Home Birth Association decided to try to negotiate a contract after Aotearoa/ New Zealand Home Birth Associations conference in Auckland in May 1992. At the conference, it was decided that home birth associations should attempt to tender for contracts to provide home birth services. A working party of the Manawatu Home Birth Association established a trust called the 'Community Birth Services Trust' to tender for a contract with the Central Regional Health Authority. This contract was finally signed more than three years later in December, 1995. The contract included a \$30,000 establishment grant to enable them to set up as a business (Griffin and Walsh-Tapiata, 1998:36). The contract was signed for three years and is being renegotiated as this thesis reaches completion.¹⁷

¹⁶ In 1996/7, 32% of births in the Central Regional Health Authority area were funded under direct contracts, compared to 7% in North Health, 2% in the Midland region and 19% in the Southern Health Authority region (Performance Management Unit, Ministry of Health, 1998:52-53).

¹⁷ Participants from the Manawatu Home Birth Association interview expressed anxiety about the uncertainty of whether the contract would be renewed, particularly as the Central Regional Health Authority contracting manager they

The Community Birth Services contract includes the purchasing of antenatal classes, antenatal care by a midwife or shared care from a midwife and a GPO,¹⁸ midwifery care or shared care during labour and birth at home, postnatal midwifery care, a nappy service or seventeen hours home help, access to resources such as a library, birth pools and breast pumps which are all free of charge for women planning to birth at home (Manawatu Home Birth Association interview, 24 March, 1997). Community Birth Services employ a part time coordinator/ administrator "with both excellent skills and a home birth philosophy" (Griffin and Walsh-Tapiata, 1998:36). Unlike the Tauranga contract, the Community Birth Services contract is not capped. They claim for each woman who attends antenatal classes and/ or books for a home birth through their organisation (Manawatu Home Birth Association interview, 24 March, 1997).

Community Birth Services rent a centrally located house that includes space for antenatal classes, which is also used for meetings of the Manawatu Home Birth Association and La Leche League. The home birth midwives and some domino midwives use offices in the house. It is also a drop-in centre for women who are interested in home birth or want to use the Community Birth Services library. Also, the Trust has a commitment to midwifery education and, at the time of the interview, three newly graduated midwives were working through the Community Birth Services and being mentored by more experienced home birth midwives (Manawatu Home Birth Association interview, 24 March, 1997).

An alternative Māori service is being developed through the Community Birth Services Trust. A Māori midwife runs antenatal hui for Māori women through Community Birth Services. This was not required under the contract with the Central Regional Health Authority. However, the Community Birth

had worked most closely with had left her job (24 March, 1997).

¹⁸ A GPO is a general practitioner with obstetric qualifications.

Services Trust deed includes a commitment to honour the Treaty of Waitangi and to produce all printed information resources from Community Birth Services in both English and Māori (Manawatu Home Birth Association interview, 24 March, 1997).

Since Community Birth Services has held a contract, there has been a significant increase in the numbers of women choosing to birth at home in the Palmerston North area. In the first year, just over 180 women accessed birthing services through Community Birth Services, almost twice as many home births as in previous years (Manawatu Home Birth Association interview, 24 March, 1997). In 1998, 25% of their clients were Māori whānau and a Māori home birth group has been formed (Griffin and Walsh-Tapiata, 1998:37).¹⁹

For the Tauranga, Manawatu and the Auckland Home Birth Associations' members who have been involved in contracting, consumer 'control' over service provision is a critical issue. Celia from the Auckland Home Birth Association argues: "We want to be the ones who set up these services so we can ensure that they are consumer focused" (Auckland Home Birth Association interview, 16 June, 1997). This is also reflected in the membership of the Community Birth Services Trust board. Nicole and Judith explained in the interview with the Manawatu Home Birth Association:

Nicole: And it meant the we had, the women, the consumers had the power. It wasn't going to the midwives, it wasn't going to the GPs, and it was like, personally - as a group - we were the ones that were going to lead it. And the reason we called it Community Birth Services, not Home Birth Services, was because we thought that at some stage in the contract, we might be able to

¹⁹ This group had not yet formed when I conducted the interview with the Manawatu Home Birth Association.

open ourselves up to being in control of even more services and choices for women.

Judith: And that's the way the trust was set up, is to be consumer heavy. So there's one GP, one midwife, and three consumer reps. In fact [another consumer] has been co-opted so there's four consumer reps now. ... The chairperson can't be a midwife or a GP, so consumers still hold that balance.²⁰

(Manawatu Home Birth Association interview, 24 March, 1997)

Contracting is framed by activists from the Auckland and Manawatu Home Birth Associations as an 'opportunity' for a consumer lead service, where consumers, or representatives of consumers, control the services they access. Simultaneously, contracting is framed as a 'compromise' aimed at securing forms of consumer oriented home birth services in the face of an uncertain future in the arrangements for providing home birth services.

Constructing contractual identities?

How do home birth associations, or the members of these groups collectively, re-position and re-present themselves as potential contract-holders? From the interview participants' accounts of entering contract negotiations, several different assessments of the political opportunity structure of contracting emerge which reflect the ways in which each association strategically constructed a collective identity to argue for a legitimate, and even a privileged contractual standing. In doing this, activists play to some of the conflicting discourse about contracting with community groups.

²⁰ Consumer representatives hold a majority in the Trust, with two consumers elected by the Manawatu Home Birth Association and the third through Māori networks.

While the members of the Tauranga, Auckland and Manawatu Home Birth Associations I interviewed all utilise a rhetoric of consumer control over service delivery, there are subtle differences in the ways they represent themselves as consumers with the capacity to provide these services. These activists have to position themselves in relation to two (and more) sets of politics of contractualism which coexist and strain against each other in the health sector. State actors involved in making decisions about purchase of service contracting hold different and even contradictory views about what contractualism should entail. One set of politics supports contracting with voluntary or community groups as a means to deliver “more appropriate services to many groups in society” (Upton, 1991:123). Another set of politics advocates a competitive tendering environment, where funding agencies do not favour certain kinds of provider groups over others.

Bill English, Minister of Health, 1996-1999, at a meeting with a member of the Southland Home Birth Association, presents the case for contracts with voluntary agencies. He said:

We have across the country in the last four or five years a lot of volunteer organisations that we do business with. ... And I am very keen on that because often these groups have a better understanding of the needs. ... If we can get decision making about how to allocate those resources, how to use the money or staff time on deserving cases, done by people who are close to it, then we don't have to use a bureaucratic system which often can miss out some who are in need (*Southland Home Birth Association Newsletter*, September/October, 1999:16).

English argues that contracting with voluntary groups has advantages for the government as these kinds of organisations have an inside knowledge of the needs of particular communities and they can design better quality services for those communities. He suggests that through contracts, voluntary organisations can be harnessed to meet the government's

objective of 'targeting' services to those "deserving cases" with the greatest needs.

This discourse of contracting to groups connected to community networks as a means to improve health services has provided critical leverage for Māori groups seeking more self-determination through becoming contract holders. Kirsty Smith, a programme manager from Tūranga Health in Gisborne comments that through a contract with the Health Funding Authority, they are able:

... to come from a Māori perspective - more so, I don't think it's perfect yet. We don't have a purely Kaupapa Māori service. I'm sure some of the more staunch ones would say it's only a step, a drop in the bucket - and that's true. But far more able to justify the results, justify outcomes from a Māori perspective than was ever there before. A lot more freedom to run Kaupapa Māori services - to run things identified by Māori need, identified by consumer need, identified by whānau need rather than having the need identified from somewhere else. ... They put that element of Tino Rangatirotanga in (Radio New Zealand, Insight, 28 August, 1998).

Lobbying efforts by Māori activists through the 1990s secured more acknowledgement of this form of contractualism and it became an explicit policy to contract with Māori provider groups in the 1996 Coalition health policy agreement (Ministry of Health, 1998:4; see also; Health Funding Authority, 1998:24; Minister of Health and the Health Funding Authority, 1999:5, 9, 194-195). At the same time the Health Funding Authority frames "fostering the development of more Māori health service providers" as a Treaty of Waitangi obligation (Health Funding Authority, 1998:24) which places limits on the opportunities for the utilisation of this discourse by other community initiatives.

The other approach to contracting or purchasing health services is informed by agency and market theories. A "neutral competitive environment" for service providers tendering for health funding authority contracts is considered essential to improve the efficiency of health services (National Interim Provider Board, 1992:38-39). In this view contracting decisions should be based on the best cost, quality and risk equations offered in tenders (Health Reforms Directorate, 1992:4; see also; Southern Regional Health Authority, 1995:5; Upton, 1991:34). Thus, the identities of providers, whether they are for profit, non-profit, publicly owned, voluntary or self-advocacy community organisations, is not necessarily significant, although their business capacity is important. This approach also warns of the dangers of 'lock-in' where neither party can exit the contractual relationship, for example if purchasing authorities are instructed by the Ministry of Health to buy services from Māori provider groups (Althaus, 1997:148). This can be avoided, advocates of market approaches to contracting argue, through open contestable, short term contracts (McGuire, 1997:114; Smith and Lipsky, 1992:243-244). However, this market oriented approach to the health system has not been popular with the public. Toni Ashton notes that dissatisfaction with health policy was the number one election issue in the 1996 elections (1999:134). Even Graham Scott, former secretary of the New Zealand Treasury suggests that: "the government purchasing agencies have not established themselves as embodying the government's commitment to health services" (1997:162).

The politics of justifying contracts with voluntary agencies opens up the opportunities for community groups not only to supply services, but, also to negotiate the definitions of the 'needs' that these services should meet. The argument that community groups will provide a better service because "often these groups have a better understanding of the needs" (English, *Southland Home Birth Association Newsletter*, September/ October, 1999:16) enables community groups to utilise contracting as a strategy to

engage in what Nancy Fraser terms as the 'politics of need interpretation' (1989:145; see also Higgins, 1997:5-6). In an agency theory approach, the purchasing authorities determine the needs and therefore the services they want to purchase (Althaus, 1997:145; Dalziel and St John, 1999:87). This demonstrates one way in which agency theory becomes complicated when applied to the state sector. Community groups can simultaneously position themselves as 'agents' and as citizens vested with a democratic right to make claims on the state. At the same time, contracting can enhance the power of state authorities to "enforce [their] own interpretation of a particular need" through tight service specifications and a refusal to fund "work that involves alternative interpretations of need and alternative ideas about the requirements for need satisfaction" (Higgins, 1997:6).

The tension between the 'supporting community based health projects' and the 'political and competitive neutrality' discourses presents a peculiar challenge to community groups interested in contracts to provide health services. These discourses can be invoked by purchasing agencies at different times and work to delimit each other. On the one hand, it opens opportunities for community groups to reposition themselves as providers with a certain set of key skills. This can 'fit' with governmental agendas to meet consumer demands that cannot be satisfied through mainstream health services and to counter public criticisms that the health funding authorities are more concerned with budgetary restraint than with 'health'. At the same time, the competitive neutrality discourse makes it difficult for community groups to use a 'rights claim' to argue for contracts and can be deployed by state managers to "contain runaway needs" (Fraser, 1989:172). Furthermore, it pushes community groups to become more business oriented to be able to compete with providers who already have business management skills (Nowland-Foreman, 1998:114).

I argued that the Tauranga Home Birth Association activists deploy a

language of community needs and community empowerment to frame their claims for a contract, for example, a home birth service “needs to be provided by the women who use it, because they know what they need” (Hannah, Tauranga Home Birth Association interview, 25 March. 1996). Participants in the Manawatu and Auckland interview groups legitimate their claims for contractual status through utilising different combinations of claims to community and business expertise. This reflects, in part, the institutional contexts in which each group began negotiating contracts. The Tauranga Home Birth Association was drawn into contracting in an initiative aimed specifically at community groups whereas the Auckland and Manawatu Home Birth Associations entered into tendering along with professional provider organisations. It also reflects key aspects of the histories of each association and the particular groups of women activists.

The Auckland Home Birth Association members who are involved with their contract proposal articulated a version of community expertise that differs from Hannah’s. They represent themselves as policy activists, rather than ‘women who use the service’. As I discussed in chapter five, the Auckland Home Birth Association has been more politically oriented than other associations. The women from the Auckland Home Birth Association involved in tendering are long term activists who are also involved in the Auckland Maternity Consumer Council and have links to other women’s health groups in Auckland (Auckland Home Birth Association interview, 16 June, 1997).²¹ As a result of their tender proposal and their activities on the Auckland Maternity Consumer Council steering committee, Celia

²¹ This is an advocacy/ lobbying group made up of 78 member organisations with an interest in maternity services in the Auckland region (Auckland Maternity Consumer Council, 1993:1). In 1993 the Auckland Maternity Consumer Council was contracted by the Northern Regional Health Authority to undertake a consumer consultation process to develop quality indicators for maternity services in Auckland (Auckland Maternity Consumer Council, 1993:61). In 1994, the Council had North Health support to produce an information pamphlet, although North Health withdrew support as the pamphlet went to print, after complaints from some doctors about the content (Strid, 1994:95).

comments: "there's always a home birther jumping up and down in front of them [Northern Regional Health Authority managers] wearing one hat or another" (Auckland Home Birth Association interview, 16 June, 1997).

The Auckland Home Birth Association contracting group's connections are not to groups of women who have recently birthed at home, but to networks of activists who are engaged in political advocacy in relation to women's health issues within policy making arenas. Their field of expertise comprises the maternity policy debates: the key actors and networks involved in policy making, the language and 'rituals' of policy processes and ways in which a home birth consumer viewpoint can be translated into a form that can be taken up in these debates. This knowledge provides the resources for home birth activists from Auckland to design a service that can be both a 'business' and a community initiative.

The participants from the Manawatu interview group who have been involved with the Community Birth Services contract use an argument of skills in business and policy language that is not based on historical political engagement and personal connections to policy makers. They argue that their background as educated middle class women enabled them to negotiate a contract. This argument was made in the following discussion:

Rea: Thinking about your home birth group in comparison to other home birth groups that you know, or impressions you get about other groups through reading their newsletters - how do you think yours is different?

...

Judith: The other thing which is something you said Nicole, was how middle class we are.

Christina: I'm claiming that!

Nicole: Me too, compared to other associations, I think that Manawatu [Home Birth Association] is a real middle class group.

...

Judith: If you look at struggles, often it is the middle class who get pissed off and want to change something for themselves, and then the other groups come along and say "well look, this is not good enough, let's do this" ...

Nicole: Yeah, but I don't think we would have negotiated for a contract if we hadn't have been that sort of a group of women, with our backgrounds, that knew which way to go about it.

Judith: That's dead right. Where do you get that sort of information, that cultural capital?

(Manawatu Home Birth Association interview, 24 March, 1997)

Nicole and Judith suggest that the particular membership of their committee tends to be more middle class than other home birth association committees.²² This, they argue, contributed to their success in contracting because the process favours those with certain knowledge and skills which are more accessible to people from middle class backgrounds. These skills, a member of the Manawatu Home Birth Association interview group remarked, enabled them to negotiate "improved services" for women and their families interested in birthing at home in the Manawatu.

I do not want to overstate the differences between the collective identities crafted in each of these groups. They are 'variations' on a theme of groups of women associated with home birth networks who seek ways into ensuring forms of consumer control in the design and delivery of home birth services. The Auckland, Tauranga and Manawatu Home Birth Associations all included members who learned skills in political lobbying during the late 1980s and therefore frame contracting in political terms. Nonetheless, these accounts demonstrate that a complex intersection of factors influence the ways in which each group negotiates claims to a

²² One of the participants in a Tauranga Home Birth Association interview group commented that she was from a working class background, while another talked about her lack of qualifications, job opportunities and money (Tauranga Home Birth Association interview, 25 March, 1996).

position of representing a 'community' and to a capacity for managing a 'business'. These factors include the skills available among group members, the history of the group as well as the backgrounds of its individual members.

The significance of having committee members who are knowledgeable about maternity politics was raised by a member of the Christchurch Home Birth Association. She suggests that the presence of members with long term involvement in the home birth association is important for the association to be able to contemplate contracting:

Tessa: I think too that the background is pretty important. That if you're going to have women contracting you've got to have women there from the start who have background knowledge, at least a couple. I mean you look at Auckland ... you've got a lot of women that have been there a long time. Same with Palmerston North, they've got that.

(Christchurch Home Birth Association interview, 25 Sept, 1997)

Among the associations who are interested in contracts, all have several long term members. As Tessa suggests, it has not been associations with many new committee members who are taking up contracting. In part this may be attributable to practical considerations - new members are more likely to have younger babies and therefore may not be in a position to meet the demands of negotiating a contract and managing a business. Tessa also makes the argument that long term involvement is necessary to build up a knowledge of the intricacies and complexities of home birth services that need to be taken into account in negotiating a contract.

Conclusion

The rhetoric of the health reforms and that of contractualism has opened up new opportunities for home birth associations to consider repositioning themselves as providers of home birth services. At the same time, other meanings and practices attached to these changes mitigate against home birth associations being able to access contracts. For instance, health services purchasing authorities are not interested in 'consumer control' arguments and there might be less risk and lower transaction costs contracting with larger provider groups who offer a broader range of services. Alongside these, purchasers utilise understandings that make contracting with home birth groups more acceptable. These contracts may offer means of targeting services, lowering intervention rates for hospital births and perhaps also a cheaper service as the costs of administration provided by a home birth trust may be less than in contracts where this is provided by professional managers. Statutory authorities might also consider contracts with home birth associations because these kinds of community initiatives generate support, at least amongst those who might want to use such services, which might spill over to more credibility for the health funding authorities.

The groups who participated in the interviews for this research represent claims to contractual standing through emphasising different resources and strengths of their groups to 'fit' with the meanings deployed by purchasing authorities. Thus, one group emphasises their connections to grassroots community networks, another group plays on their knowledgeability of policy making while a third seeks to establish their business skills and ability to deliver an improved service. In the following chapter, I will examine some of the problems associated with social movement organisations contracting with state agencies to provide a health service. Then I will

return to the question of whether the new contractualism can be framed as a new political opportunity structure.

10

The challenge of contracts: home birth associations as providers of home birth services

Introduction

In the previous chapter I indicated that 'contracting' is alternately framed as an 'opportunity' and as a 'compromise' by home birth activists. Some activists view contracting as an opportunity to provide better services for women and, perhaps more importantly, to maintain a home birth political voice in policymaking and secure points of access for community groups to provide state funded services. Other home birth activists are more ambivalent and concerned about possible negative outcomes of contractualism. Recent research about voluntary organisations that deliver services under contracts with statutory authorities indicates that contracting presents both risks and benefits for voluntary agencies (see for example;

Higgins, 1997; Nowland-Foreman, 1998; Smith and Lipsky, 1992; Weeks and Aggleton, 1996). This chapter examines these critiques of contractualism and looks at the ways in which the home birth activists who participated in this research make sense of, and try to manage, the complex pressures of contracting.

There is a growing body of work about how the new contractualism restructures the voluntary sector, and a broad consensus is emerging among researchers in this area. When voluntary agencies are drawn into purchase of service contracts with statutory authorities, these theorists argue, they also become subject to tighter forms of statutory control. As a consequence, contracted voluntary organisations may change in ways that signal a substantial break with the past.

The literature on voluntary sector contracting indicates that the services a voluntary organisation provides are potentially determined more by government than community initiative (Higgins, 1997:3-6; Nowland-Foreman, 1998:114-116; Smith and Lipsky, 1992:249; Weeks and Aggleton 1996:115, 117). Voluntary organisations may also be pushed to take on corporate structures to meet the accountability and efficiency demands of the funders such that "users play a decreasing role in the organisations themselves" (Weeks and Aggleton 1996:113; see also; Dalziel and St John, 1999:82; Nowland-Foreman, 1998:116-117). Another problem for voluntary organisations under a contract funding regime is that relationships between voluntary groups may become less cooperative as competition for funding and secrecy requirements undermine trust between groups (Nowland-Foreman, 1998:119-120; Weeks and Aggleton 1996:118). Perhaps the most significant shift for home birth activists is the conclusion of several analysts that contractualism jeopardises the political advocacy and community development work done by voluntary organisations (Higgins, 1997:5-6; Nowland-Foreman, 1998:116, 120; Weeks and Aggleton 1996:113, 119-

121).

Gary Stoker cautions against overly generalised statements about the effects of contractualism and the broader shift in styles of governing or 'governance' that he examines. He argues that the outcome of contractual relations between statutory and non-governmental agencies "is determined not only by the resources of the participants but also by the rules of the game and the context of exchange" (Stoker, 1998:22). That is, we need to attend to the specific social historical locations of groups involved in contracting, as well as the particular policy approach to negotiating contracts taken by statutory authorities. Anna Yeatman also argues that contractualism can be constituted in different ways. One way is through "a secretive state, oriented to making discrete deals with corporate players" (1991:120). She advocates a 'new contractualism', in which all citizens have a "right to participate, to have their voices heard and to negotiate the conditions of their governance" (cited Sullivan, 1997:7). I will return to these ideas in the conclusion.

Although there has been a lot of interest in contracting among home birth associations, only one association, the Manawatu Home Birth Association, had a contract for a complete home birth service at the time I conducted the interviews for this research. Furthermore, this contract had only been running for fifteen months when I interviewed members of this association. Another three associations held contracts for parts of a home birth service. These included the Tauranga, Christchurch and Dunedin Home Birth Associations.¹ There is, therefore, a paucity of material on which to assess the effects of contracting on home birth associations. Home birth activists

¹ At the end of 1999, the Auckland Home Birth Association and Community Birth Services associated with the Manawatu Home Birth Association held contracts for a full home birth service. The Christchurch and Dunedin Home Birth Associations were both still contracted to provide antenatal classes.

themselves attempt to anticipate and theorise the possible risks that might be involved in contracting. These risks were articulated in the interviews, particularly by members of the Christchurch and Wellington Home Birth Association interview groups and in the second interview with the Tauranga Home Birth Association. Thus, this chapter raises preliminary issues and questions for further research.

The uncertainties of tendering

The home birth activists I interviewed considered the key problem of contracting to be the massive amount of voluntary work involved in setting up a contract with no guarantees that their bids will be successful.² The Wellington Home Birth Association's experience of contracting illustrates that successfully mobilising the resources necessary to put together a tender does not ensure getting one. The Wellington Home Birth Association set up a sub-committee to work out a contract proposal in 1993. Through information sharing with the contracting committee of the Manawatu Home Birth Association, their initial tenders were similar. Both groups were in the same health region and dealt with the same contracts manager. However, the Wellington committee felt that the Central Regional Health Authority was not interested in their tender. Erica, the only consumer member of the contracting group who was still involved in the association, argued that this was demonstrated by the way in which communication always had to be initiated by the Wellington Association, and the authority managers continually postponed negotiations. After two years, the Wellington group lost momentum and gave up trying to negotiate a contract (Wellington

² This point was made in the Christchurch Home Birth Association interview (25 September, 1997), the Manawatu Home Birth Association interview (25 March, 1997), the Tauranga Home Birth Association interviews (25 March, 1996; 13 June, 1997) and the Wellington Home Birth Association interview (25 March, 1997).

Home Birth Association interview, 25 March, 1997).

Interview participants from the Wellington Home Birth Association attributed the apparent lack of interest in their contract on the part of the Regional Health Authority to two factors. Firstly, they suspected that the health authority manager was only interested in setting up one 'pilot project' in contracting with a community group for birthing services, for which the Manawatu Home Birth Association tender was chosen. The other reason, they thought, was that professional maternity groups were negotiating larger maternity services contracts in Wellington, contracts that could include home births (Wellington Home Birth Association interview, 25 March, 1997). Hannah and Tania from the Tauranga Home Birth Association similarly believed that competition from a larger provider contributed to their lack of success in negotiating a contract for home birth services (Tauranga Home Birth Association interview, 13 June, 1997). Tania suggested that the Midland Health Funding Authorities became increasingly interested in "big primary health organisations and multi-provider organisations" rather than voluntary organisations offering specialist services (Tauranga Home Birth Association interview, 13 June, 1997).

In 1998, the Southland Home Birth Association decided to try to get a contract to provide postnatal help at home. The southern office of the Health Funding Authority responded that they were not seeking tenders for this service (Southland Home Birth Association interview, 6 October, 1998). Thereafter, they sought a meeting with Bill English, the Minister of Health and Member of Parliament for a Southland electorate. He told a representative from the Association that as a consequence of amalgamation of the regional health authorities into one Health Funding Authority, more account had to be taken of the costs associated with numerous small contracts. Therefore, the Health Funding Authority was interested in contracting with large local provider groups of GPs and midwives to

deliver maternity services. He advised the Southland Home Birth Association to explore subcontracting under such a scheme, although no large maternity services provider group operates in Southland (*Southland Home Birth Association Newsletter*, September/ October, 1998:17). The Minister's comments suggest that the theory of extracting efficiencies through competitive markets for health service providers is being replaced by greater attention to transaction costs. This is not good news for home birth associations who are interested in contracts to provide a specialised birthing option to relatively small numbers of women.

These cases highlight a critical risk for community groups who attempt to secure contracts to provide state funded services. The processes involved in remaking the organisation to be capable of negotiating a tender requires commitment and many hours of voluntary time, but success is by no means assured. As Erica states with respect to the Wellington Home Birth Association's tender: "the frustrating thing about it was that weeks and weeks of work ended in zilch" (Wellington Home Birth Association interview, 25 March, 1997). This ever present possibility for health service purchasing authorities to reject a contract proposal strengthens the disciplinary power of contractualism by exerting pressure on community groups who seek contracts to remodel themselves in ways which fit government agendas (Nowland-Foreman, 1998:110, 118).

Contracting home birth groups - 'agents of the state'?

Weeks and Aggleton suggest that funding is "a major determinant of activity" for voluntary organisations (1996:117). Forms of funding, they argue, significantly shape the kinds of services that might be provided as well as the orientation and the structure of such organisations. For example,

home birth associations who primarily rely on subscriptions, donations, grant funding, and fund raising events undertake projects that are likely to be small scale, one off or short term. These might include running antenatal classes, publishing a local newsletter, holding public meetings, purchasing birthing pools, books, breast pumps, and so on, producing a video or printed information material and paying for committee members to attend the annual home birth conferences. The work associated with these sorts of activities is generally voluntary and determined by the particular interests of the committee members at any given time.

Weeks and Aggleton, and Nowland-Foreman argue that the introduction of purchase of service contracts with voluntary organisations changes the services contracted voluntary groups provide and the ways in which these are provided. Purchase of service contracts, they contend, facilitate tighter statutory control over the activities of voluntary groups, and exert pressure on such groups to become more focussed on meeting the requirements of funders than the needs of users of the service or even the wider network of participants in the organisation (Weeks and Aggleton 1996:113, 115, 117; Nowland-Foreman, 1998:114-120). Nowland-Foreman suggests that the increased use of contracts for funding voluntary groups has led to "a shift in the locus of control from voluntary organizations to government funders, in terms of determining what services are provided, for whom, and in what way" (1998:114). How do these arguments correspond with the assessments of contracting by home birth activists?

The strain of the contradictory pressures of statutory control as against the control over services by a contracted organisation was most clearly articulated by participants of the Christchurch Home Birth Association interview group. In an extended discussion in the interview, participants talked about the problems they had faced with their antenatal classes contract from the Southern Regional Health Authority. The Christchurch

Home Birth Association has run antenatal classes since 1982 (King, 1990:15). Over time, these classes developed a specific format which emphasised self-help and information sharing among the women who attended them (*Christchurch Home Birth Newsletter*, Vol. 5, No. 6, 1985:4). The classes were generally co-facilitated by a consumer and a midwife, although it was at times difficult to find consumers who were prepared to be involved, particularly as the job was not paid.³ When the Southern Regional Health Authority called for tenders in 1995 to provide antenatal classes - which they called 'pregnancy and parenting classes' - the committee members of the association viewed this as an opportunity to provide free classes to women intending to birth at home and to pay the midwife and consumer facilitators (Christchurch Home Birth Association interview, 25 September, 1997).

In the first tender in October, 1995, the Christchurch Home Birth Association named a price which reflected the cost of classes with both the midwife and consumer facilitators being paid for an estimate of ten women, their partners and/ or support people attending each set of classes. This tender also included paying a coordinator to arrange the classes and manage the claiming processes and reports requested by the health authority. The Southern Regional Health Authority had set an undisclosed 'maximum rate of payment' (Southern Regional Health Authority, 1995:4-5). The Christchurch Home Birth Association's tender was too high to meet this.

For the next tendering round, six months later, committee members from the Christchurch Home Birth Association put in another tender at the maximum rate of payment price, which by this time had been disclosed. They were given a contract. Anne, from the Christchurch Home Birth

³ In the years of 1989/90 and 1990/1991 the Christchurch Home Birth Association was successful in grant applications to pay for a consumer antenatal class coordinator.

Association explained in the interview the association committee members had mixed feelings about tendering again:

Anne: We thought long and hard about whether we wanted never to put in a lower price and stick to the high price and just say "no we carry on the way we are" or whether we'd take the benefit of getting some money which is better than we got in the past.

(Christchurch Home Birth Association interview, 25 Sept., 1997)

The Southern Regional Health Authority specified in detail the content of the classes they wanted to purchase before calling for tenders. This included information about birth in hospital. However, this did not emerge as a problem for the association. As Jackie argued in the interview, this list of contents was so long, "such an enormous screed of stuff to get through", that any topic could only be covered superficially (Christchurch Home Birth Association interview, 25 Sept., 1997). The antenatal classes contract group decided to cover information about hospital births in a session on unexpected outcomes, in terms of transfer to a hospital. A more significant problem was that the funding was not sufficient to adequately pay for the co-facilitated and necessarily small classes that the association already offered.

Within a few classes, the association contract fund could not cover the costs of paying the class facilitators. Unlike the grant funding the association had received in the early 1990s, the health authority contract stipulated that the classes had to be provided free to the users. The contract price, participants in the Christchurch Home Birth Association interview argued, could work well for hospital based classes where much larger numbers of women attended each class and room rental was not an issue, but it was insufficient to pay for their classes with midwife and consumer facilitators, guest speakers, small numbers of participants and more than the specified

minimum number of sessions. Interestingly, the Dunedin Home Birth Association also hold an antenatal classes contract. An association member, who is a childbirth educator, organises and facilitates the classes and the funding is sufficient to cover her costs. Also, they negotiated the issue of the class content differently from the Christchurch Home Birth Association, by making them natural childbirth classes (Dunedin Home Birth Association interview, 25 March, 1998). This has the advantage, it was suggested, that the classes are able to promote the home birth option to women who are interested in natural childbirth.

The Christchurch Home Birth Association committee members were not willing to compromise on the aspects that they considered to be important to the quality of the classes. The midwife and the consumer facilitators are each seen as making a different contribution to the classes and signifying the association's commitment to consumer empowerment and partnership (Christchurch Home Birth Association interview, 25 Sept., 1997). The small size of the classes makes it easier for those attending the classes to participate in discussions. However, these arguments had not prevailed with the Southern Regional Health Authority.

The consumer class facilitators were resentful about not being paid. As Tui commented: "The RHAs are getting away with cheap labour" (Christchurch Home Birth Association interview, 25 Sept., 1997). Nowland-Foreman found, in his research on a large voluntary organisation in New Zealand, that people were often less willing to make a voluntary contribution to provide a service defined under a government contract than to those that came out of the organisations own initiative (1998:119). The interview participants noted that another antenatal class provider who did not get a contract was forced to cease holding classes because women sought out the free classes. In the interview, Tui argued that the association should try to do more publicly to expose how the underfunding was reducing the

quality of antenatal classes. Other participants argued that not only was this strategy unlikely to lead to increased funding, it might also jeopardise retaining the contract (Christchurch Home Birth Association interview, 25 Sept., 1997).

At the time of the interview, the association was pursuing another strategy. They were establishing a trust (the Christchurch Home Birth Association itself is not a legal body) to apply for grants funding to cover the shortfall from the contract. This proved successful. Community grants funding agencies seemed familiar with the problem of underfunded contracts in the health sector and were prepared to allocate grants to organisations facing this problem.

Holding a contract had another cost to the Christchurch Home Birth Association. The contract also specified that the classes could not ask participants to join the association. The classes had previously been an important avenue for enlisting new members for the association and since the contract there had been a noticeable decrease in the numbers of new members and newsletter subscriptions for the association (Christchurch Home Birth Association interview, 25 Sept., 1997).

Nowland-Foreman makes an interesting distinction between 'contracting out' and 'contracting in' of social services which is pertinent to the different experiences of contracting among home birth associations. He states that:

In what could be described as contracting in, social services previously provided much more autonomously by independent voluntary organizations are standardized, more narrowly specified, and brought under tighter government control and supervision through the vehicle of purchase-of-service contracts (1998:115).

The Southern Regional Health Authority 'contracted in' the Christchurch

Home Birth Association antenatal classes. Nowland-Foreman argues that 'contracting in' funding approaches exacerbate problems associated with contracts undermining the autonomy of voluntary organisations with respect to service provision. When voluntary organisations pick up contracted out services, he suggests, this can often bring renewed energy to the organisation, although over time the effects may be similar to those of contracted in services (1998:117).

The home birth associations that are interested in contracts to provide home help or a complete home birth service are seeking to extend their activities through picking up services that the health funding agencies are contracting out. To examine these, we need to attend to the historical and social complexities of maternity politics in New Zealand, which shape what contracts might represent for home birth associations. Unlike other parts of the voluntary sector, it has been extraordinarily difficult historically for women to carve out more than partial and informal measures of control over services. In this context a contract offers home birth activists opportunities for more autonomy and control with respect to a maternity service.

Sarah McGee, a kaitiaki midwife from Gisborne argues that contracting has enabled her community to "reclaim the traditional birthing practices ... and we are talking about tino rangatirota, the right to their taonga" (Radio New Zealand, Insight, 28 August, 1998). Home birth and Māori activists who pursue contracting view it as a means to gain more formal control over a health service than they previously had, even if this is within the constraints of the funding authorities' requirements.

Several home birth associations began working on tender proposals for a complete home birth service shortly after the health reforms were

announced.⁴ However, except for the Community Birth Services contract in the Manawatu, the regional health authorities delayed these negotiations while they were negotiating the Section 51 schedule for paying health professionals who offer primary care maternity services.⁵ A committee member of the Wellington Home Birth Association argued that: "they didn't know actually what they wanted to tender out" (Wellington Home Birth Association, 25 March, 1997).

Section 51 has provided a mechanism for health funding managers to determine the specifications for maternity service contracts. It sets out fixed fee contracts for specified modules of care that replaced the fee for service system that had previously existed. The regional health authorities jointly negotiated Section 51 with the New Zealand Medical Association and the New Zealand College of Midwives.⁶ These negotiations were protracted and involved significant disagreement and many GPs have since stopped providing maternity services (National Health Committee, 1999:44).⁷

Section 51 not only specifies prices, it also details a set of service specifications for maternity care. These include: lists of the information and services to be offered to women during pregnancy, a requirement that the lead maternity carer and client formulate a care plan, the services health

⁴ These included the Auckland, Tauranga, Waikato, Wellington and Manawatu Home Birth Associations.

⁵ Six months after Section 51 came into effect, the health system began another period of restructuring and over this time, health sector administrators were again unwilling to negotiate any new contracts (*New Zealand College of Midwives, National Newsletter*, Issue 10, 1998:17).

⁶ Consumer representatives were not included in these negotiations because the regional health authorities constitute themselves as acting on the consumer's behalf. The New Zealand College of Midwives, thus, included a consumer representative from the Manawatu Home Birth Association on their negotiating team.

⁷ The National Health Committee report into maternity services noted that the number of GPOs claiming off Section 51 has dropped from 626 in September 1997 to 429 in March 1999. The number of midwives claiming off Section 51 has remained constant at around 780 (1999:44).

professionals must provide for labour and birth in hospital or at home, a minimum number of postnatal visits and handover of care to a well child service (Joint Regional Health Authorities Maternity Project, 1996; Health Funding Authority, 1998). Appended to the notice is a set of 'guidelines for referral to obstetric and related medical specialists'. These were included at the instigation of medical practitioners and resisted by the New Zealand College of Midwives and maternity services consumer groups who view 'risk lists' as a means for doctors to retain control over childbirth.⁸

The referral process outlined in these guidelines defines three levels of referral. These include a list of conditions for which a lead maternity carer "may recommend to the woman ... that a consultation with a specialist is warranted", or "must recommend ... that a consultation with a specialist is warranted", and for which the lead maternity carer "must recommend to the woman ... that the responsibility for her care be transferred". Additionally, any request from the woman for a referral preempts the use of the list (Transitional Health Authority, 1997:5). This phrasing is significant for home birth activists because it suggests that it is a woman's choice whether to follow up on such recommendations. Thus, this list can be used in a partnership relationship as part of the information that a women can use to make choices for birthing.

The Section 51 specifications cover entitlements for women to services rather than protocols for managing pregnancy and childbirth. They are, thus, different from the kinds of recommendations made in the 1982, *Mother and Baby at Home* report which proposed requirements for the surveillance of domiciliary midwives and GPs and medical definitions of

⁸ The New Zealand College of Midwives included a consumer representative as one of the five College representatives on the "Maternity Referral Criteria Project" (*New Zealand College of Midwives, National Newsletter*, June/ July, 1994:15 17).

who would be eligible for a home birth (Maternity Services Committee, 1982).⁹ This shift is indicative of the uneasy intersection between the increasingly influential discourses of the market approach to consumer choice to enhance competition, on the one hand, and the women's health activists/ maternity services consumer activists deployment of choice as a means to challenge the medical monopoly over decision making in personal health services, on the other.¹⁰ As a result, home birth activists who pursue contracts are prepared to negotiate contracts within the terms set out in the Section 51 notice, while at the same time, this positions them as another provider within a regulated market for maternity services.

At the time of the interview, the Auckland Home Birth Association noted that North Health had made it clear that any contract between the two parties would be capped at the same level as Section 51. Thus, the association contracting group were seeking a contract where they would redistribute the aggregated individual payments for each woman in a way more suited to providing a quality home birth service. Celia explained this with respect to their negotiations with North Health:

Celia: Section 51 has become a compromise. ... The RHA, in negotiating with two groups, has put things into that contract that midwives don't use. But it's in the overall budget. So we are hoping to shift that. ... Midwives need a lot more in the postnatal module. ... They are not going to do ten scans so [we can say to the RHA] "give us more in the postnatal care". ... And also press them to honour the statements they made about providing home help for women who have had home births.

(Auckland Home Birth Association interview, 16 June, 1997)

⁹ See chapter six of this thesis.

¹⁰ This point was made by Paula Treichler with respect to birthing politics in the United States (1990:114).

The proposals for a home birth service by the Tauranga Home Birth Association sought to include paid home help and paid coordinators who would visit women planning to birth at home to inform them about the service (Tauranga Home Birth Association interview, 25 March, 1996). Hannah noted, in the second interview with members of the Tauranga Home Birth Association, that the Midland Regional Health Authority managers had indicated that they were not willing to fund these services (Tauranga Home Birth Association interview, 13 June, 1997).

It is interesting to note that the Tauranga, Manawatu and Auckland Home Birth Association tenders all shift funding from some services included in antenatal specifications to postnatal services for women/ families who have just become the caregivers for a new baby.¹¹ This may reflect the home birth orientation to birthing, which defines pregnancy and birth, in most cases, as 'normal' life events. Antenatal monitoring to predict possible complications in birthing is, therefore, less of a priority than support after the birth. Also, one key difference between the Section 51 specifications and the domiciliary midwifery benefit schedule is the number of recommended postnatal visits from a midwife. Under the midwifery benefit, ten visits were funded on a fee for service basis over the first fourteen days following the birth, while Section 51 requires a minimum of five in the first four weeks (Health Funding Authority, 1998). Contracting creates an

¹¹ In the interviews the following points were made about home help. It was argued that not all women who birthed at home might want home help, but that there were women who birthed in hospital because they could not get the rest they needed at home (Auckland Home Birth Association interview, 16 June, 1997). Other participants commented that some women birth at home because they have no one who can look after their other children or dependents if they go to a hospital and these women often need practical help at home (Tauranga Home Birth Association interview, 25 March, 1996; Southland Home Birth Association interview, 6 October, 1998). Those who participated in the interview in Dunedin had a lively debate where Clare, a midwife, asserted that there were more urgent needs for funding in the health sector. The other participants argued that groups needed to fight for preventative health measures, such as support for families with new born babies. These, it was argued, could also lead to cost savings later (25 March, 1998).

opportunity for home birth associations to offer women who want to birth at home a better postnatal service - within the limitations set by the health funding authorities.

While the Section 51 notice offers the statutory funding authorities more control over maternity services, it also presents a way for consumers and those interested in less medicalised forms of birthing to gain more control than was possible under previous health service regimes. Section 51 facilitates the negotiations of such 'adjustments' and innovation, at the same time as the standardised entitlements that it contains limits the degree of possible flexibility in designing services to meet the needs of a particular client group.

Section 51 is a national system that provides political opportunities for home birth associations throughout the country. However, whether these opportunities are activated depend on the orientations of home birth associations. These include whether an association focuses on support for home birth mothers or on 'management' and political responses to contracting. As the various home birth associations' encounters with contracting illustrate, access to contracts is also determined by the approach of particular contract managers in the regions.

Contracts with midwives - home birth groups as 'middlewomen'

Consumer control over home birth services is also tempered by the dependence of contracting trusts on midwives to provide antenatal, birthing and postnatal care. Moreover, they need particular kinds of midwives - those who are primarily interested in attending women who

plan to birth at home. Midwives, however, do not need home birth associations to access payment as they can choose to be independently contracted under Section 51. When home birth associations take up a contract for the entire home birth service, it potentially changes the relationships between home birth associations and home birth midwives.

This was one of the reasons given by participants in the interview with the Christchurch Home Birth Association for not contracting.

Jackie: I think part of that decision too was being able to maintain that independence of being able to not be attached to any midwives. They can be part of the association, but the consumer power not to be attached to - to maintain that ability for the consumers to be able to say "hey look at your practice and"

Belinda: To be able to be more objective and further away.

(Christchurch Home Birth Association interview, 25 Sept., 1997)

Jackie expressed her group's concern that contracts with particular midwives providing home birth maternity care can potentially create conflicts of interests between protecting the group's contract and ensuring that the midwives provide a quality service. The Christchurch Home Birth Association members suggested that this could compromise their autonomy as a consumer group.

Tania and Hannah from the Tauranga Home Birth Association also argued that contracting introduces new sources of strain between midwives and home birth collectives:

Tania: There's a lot involved when you start to pay health professionals - like their continued support for your organisation when you have to make trade-offs for doing administration and paying them.

Hannah: It creates a triangle - between the woman and the midwife and the provider organisation which could be

really strong - but it also has problems.

(Tauranga Home Birth Association interview, 13 June, 1997)

In setting up a contracted home birth service, association members have to negotiate payments with the health funding authority on one side and with the midwives who will work for the service on the other. If the home birth group are unable to obtain sufficient funds then, as Tania points out, 'trade-offs may need to be made' between how much the midwife will be paid and how much will be directed towards administration and the other services specified in the contract. If a home birth provider trust is unable to negotiate a higher price than the capped level under Section 51, midwives contracted to the home birth trust might receive less than if they claimed directly through Section 51.

The focus of discussion on contractual relationships between home birth midwives and the association in the Auckland and Manawatu Home Birth Association interview groups was on the benefits their organisation could offer to home birth midwives. As home birth groups attempt to position themselves as 'middlewomen' between the purchasing authorities and the midwives, it poses the question of what value does a home birth contract add for the midwives who attend births at home? How can a home birth group pursuing contracting attract midwives so that they can provide a better service to women birthing at home?

The interview participants suggested that they could offer midwives less paperwork as the contract holder would file the claims. Also, by providing a service to women/ families who are interested in birthing at home that might suit some better than the Section 51 service, it might help contracted midwives to attract more clients (Auckland Home Birth Association interview, 16 June, 1997; Manawatu Home Birth Association interview, 25 March, 1997). The success of Community Birth Services in increasing the

numbers of home births in Manawatu demonstrates another possible benefit for midwives working with a contracted home birth group. Participants in the interview with the Manawatu Home Birth Association argued that the contract encourages more women to consider birthing at home because it simultaneously seems to confer an official approval of home births while still constituting it as an alternative to mainstream services (Manawatu Home Birth Association interview, 25 March, 1997).¹² Working for a home birth trust can also be constructed as a way of practicing partnership between midwives and a consumer group (Griffin and Walsh-Tapiata, 1998:37).

There is another dimension to the challenges posed by the potential position of being a fund holder for home birth services. During the Section 51 negotiations the New Zealand College of Midwives began to investigate the option of setting up midwifery provider organisations to access contracts with the regional health authorities. This was in response to concerns that the regional health authorities were not interested in finalising Section 51. Once the Joint Maternity Project had worked out the maternity services they wanted to purchase, they saw negotiating direct, separate contracts with providers as an opportunity to avoid the difficulties associated with trying to forge an agreement between the New Zealand Medical Association and the New Zealand College of Midwives. At the time when I conducted most of the interviews for this research, the midwifery provider organisations were not yet established. However, one has since been commissioned in the southern region of New Zealand (*New Zealand College of Midwives, National Newsletter*, Issue 10, 1998:22).

There are some important differences between the organisational form of

¹² this argument was also made by members of the Christchurch Home Birth Association (Christchurch Home Birth Association interview, 25 September, 1997).

home birth trusts and midwifery provider organisations. The Southern Midwifery Provider Organisation is basically a payment processing agency that offers midwives streamlined maternity notes (client record) as well as collating the statistics each midwife needs for her annual standards review.¹³ The maternity notes include a copy for the client, a copy to claim from the Midwifery Provider Organisation and the statutory copy for the midwife. The Community Birth Services Trust, by contrast, provides a range of other non-midwifery services for women interested in birthing at home and a house - where midwives and birthing women can hold meetings and 'drop in' (Griffin and Walsh-Tapiata, 1998:36-37). However, the tight funding control by the Health Funding Authority could force home birth contracting organisations to deliver the services in the same way as a midwifery provider organisation. Contracting to provide a complete home birth service could lead to greater community participation in home birth service delivery as it has in the Manawatu. At the same time, tight specification and rigid contracts may undermine this participatory engagement in community services.

It seems possible that if the current Health Funding Authority policy continues, they may prefer to contract with the Midwifery Provider Organisation rather than a number of local groups of home birth consumer representatives. Perhaps, in the future home birth groups who want to provide specialised consumer led home birth services may have to test the College's rhetoric of partnership and explore contracting with the Midwifery Provider Organisation.

¹³ The midwifery standards review process is discussed in chapter eight.

Contracting and community networks

Nowland-Foreman (1998:114-120) and Weeks and Aggleton (1996:112-114) argue that a significant risk of contract funding for community groups service delivery agencies is losing the voluntary input into their organisations as well as losing touch with their constituencies. Do home birth association contracts threaten the very networks which justify the contract? The following discussion touches on this question:

Carol (midwife): I know we're all getting into that business side of it ... but it still remains a grass roots organisation. It's still women and midwives working together in a small frame without these multi-levels of bureaucracy and stuff, and that's one of the good things about it.

Rea: Do you think that if you get the contract for providing the whole midwifery service, that there might be a risk that you wouldn't - that you couldn't keep that grass roots thing?

Hannah: We already have [lost it], to a certain extent. ... But the thing is that we still visit the women. ... [The] job as a coordinator is to go and visit the women. ... And part of our agenda with the new contract, where we are going for a big package, is that we still have that contact with the women. Though mostly it will be on a one to one, individual basis, it still keeps you referenced to the women.

(Tauranga Home Birth Association interview, 25 March, 1996)

Members of the Tauranga Home Birth Association argue that maintaining grassroots networks is essential to their collective identity as providers of home birth services. They suggest that despite the low levels of activism in the association, this can be accomplished through visits to women planning to birth at home.

Participants in the interview with the Auckland Home Birth Association argue against the view that contracting offers a way of encouraging more

active members to join their association's committee:

- Rea: If you had a contract ... do you think that might bring more people in?
- Marian: No.
- Celia: No, I don't think so. I think it's a logical step for those of us who have been involved as consumers for a long time.
- Marian: And for the midwives who have been active in home birth as supporters and providers. But I don't think that most women out there have any understanding of why - why it is so important.

(Auckland Home Birth Association interview, 16 June, 1997)

While they do not view contracting as a means of drawing new membership, members of the Auckland and Tauranga Home Birth Association interview groups suggested that there were attractive benefits for the home birth activists who were involved in contracting. One of the interview participants from the Tauranga interview group, who was also a coordinator for the antenatal workshops and postnatal home help services, reflected that: "I have this job I really love and how many people have a job they really love?" (Tauranga Home Birth Association interview, 25 March, 1996).

Being repositioned as providers might draw different kinds of people into the organisation. Sharon, member from Tauranga Home Birth Association who had joined in the year before I interviewed her explained that this was "not for political reasons but because I see it [postnatal home help] as a service we really need" (Individual Interview, Tauranga, 13 June, 1997). At the same time she talks about the difficulty of joining a group involved in such a project:

- Sharon: A lot of it goes straight over my head. And sometimes too there is a lack of interest because of a lack of knowledge, but the more I listen to others talk at core

group meetings and stuff, the more I understand and the more input I can have (Individual interview, Tauranga, 13 June, 1997).

Lisa, who had been a member of the Manawatu Home Birth Association for about a year at the time of the interview articulated a similar problem :

Lisa: I'm one of the newer ones of the group so I'm just catching on. Well, admittedly it did take me a bit of time. I had a struggle to sort of understand the difference between the two [the home birth association and the contracting trust board] (Manawatu Home Birth Association interview, 24 March, 1997).

Negotiating and administering a contract requires background knowledge and skills that can act as a barrier to new members joining because the 'entry stakes' are higher. These accounts from home birth activists involved in contracting appear to support Nowland-Foreman (1998:114-120) and Weeks and Aggleton (1996:112-114) contention that through contractual regimes, community groups can increasingly be constituted by a few trustees willing to make contracts with the state.

Members of the Manawatu Home Birth Association have observed a significant change at their monthly information evenings. These are organised by the Association not Community Birth Services. These evenings are usually attended by 35-50 women who have had home births and pregnant women and their families who are planning home births. They talked about how the midwives have noted a shift in the ways in which women respond to them at the meetings:

Nicole: Our midwives have been getting concerned that they go along to a [home birth information] meeting and they are being checked out and that they have to come along and promote themselves.

Judith: Promote themselves, yes, it is like that.

...

- Nicole: And the midwives have said that they used to come along and feel like it was a really supportive warm environment, whereas now they come along and they feel like they have got to think about what they should say, and what they're wearing and how they're going to present themselves at the meeting to all these people who have come along.
- Rea: Ah, that's very interesting, but is that connected to CBS, do you think, or is it because of other changes in the [health sector]?
- Nicole: No, I think it is the changes in the environment of health.
- Christina: I thought maybe it was CBS a bit, because maybe now we have got a house and it is all very professional and you're employing people and so maybe people are expecting a more professional thing and maybe that's why it's more like that at the meetings.

(Manawatu Home Birth Association interview, 24 March, 1997)

Nicole and Christina offer two different, but overlapping accounts of why women might view midwives more critically. Christina suggests that holding a contract with the Central Regional Health Authority to provide home birth services has led to increased expectations on the part of some clients for a 'professional' service. Nicole asserts that the different expectations of consumers from midwives is a reflection of broader changes in the health sector. While Nicole is referring to a general public dissatisfaction with health reforms, also implicated in these changes are the feminist critiques of the medical profession. As midwives become repositioned as 'professionals' they become subject to the same kinds of critical scrutiny as the medical profession.

In the interview, members of the Manawatu Home Birth Association expressed their intention to explore ways in which the Community Birth Services contract could work as a base for the formation of support groups for women interested in home birth who have not been adequately catered for in the predominantly middle class Manawatu Home Birth Association (Manawatu Home Birth Association interview, 24 March, 1997). These

include single mothers and Māori women/ whānau. Since I conducted the interview, a Māori home birth network has emerged in the Manawatu, facilitated by the community focus of the trust's activities (Griffin and Walsh-Tapiata, 1988:37).

Politicising contracting?

Does contracting offer an effective way of sustaining a home birth consumer voice in maternity services policy making? Or, does taking up contracting reduce the possibilities for challenging action with respect to maternity issues? Is it possible to use contracting as a means of providing better services for women birthing at home, while avoiding political compromise? These questions were raised in an article in the *Southland Home Birth Association Newsletter*. The writer asks members to consider that if:

... the Southland Home Birth Association is successful in its endeavour to get a contract for home help ... the group will then move from the position of consumer group to provider. The relationship with government then changes dramatically. The recent case of Tauranga home birth group losing its contract begs the question, was this a result of their continued role as a vocal consumer group who has been critical of government policy? Can a group such as the home birth association be both a consumer group and a provider, when there is going to be a direct conflict of interests at times? (September/ October, 1998:17)

Home birth activists enter into contracts with health funding organisations to improve services by directly configuring the service side of home birth. However, through holding contracts, home birth associations shift from being political activists outside the state, demanding certain policy changes and consumer representation in policy making arenas, to being

reconstituted as a provider of health services in a co-operative relationship with statutory funding bodies whose policies are determined by central government.

Some home birth association activists argue that the silencing of a political voice is a risk associated with holding maternity service contracts. This is the way members of the Christchurch Home Birth Association articulated these concerns:

- Jackie: I think that one of the advantages of staying away from contracting is staying out of the government's pockets too.
- Tui: Because you get into all of this stuff that you have to do and that you might not agree with - because you have to meet their criteria.
- Jackie: And you might be more reluctant to say something because you're getting funding from them. And in the position that we're in now we've got nothing to lose.

(Christchurch Home Birth Association interview, 25 Sept., 1997)

Similar comments were made in the Tauranga Home Birth Association interview in relation to holding a contract:

- Hannah: You have to be quite - you *are* aware that when you are within the system, that this is where you get your money from. And perhaps you shouldn't be so mean and nasty to them after all, because they might not give it to us anymore.
- Tania: We've found the last [contracting] round difficult and had to compromise our principles. And we talked ... [about going] to the press and refute that issue or whatever. But we can't or the RHA might get really hacked off and we're asking them for money at the moment.

(Tauranga Home Birth Association interview, 25 March. 1996)

These comments suggest that while some associations have tried to sustain both positions, there are considerable conflicts between managing

contracts and health activism. Either activists can attempt to retain their political social movement voice and risk other competitors 'taking over' home birth. Or, they can try to tender for contracts to deliver more home birth women-centred services and compromise their position as political activists. It is important, however, to avoid attributing the depoliticisation of home birth activism solely to the constraints of contracting. A discussion between participants from the Manawatu Home Birth Association suggested that they had become less political because through delivering the kind of service they want, there is less immediate need for political advocacy (Manawatu Home Birth Association interview, 24 March, 1997). Furthermore, a loss of political focus as a consequence of the 1990 Nurses Amendment Act, as well as the altered political opportunity structure attendant on the health reforms was noted by participants in most of the interview groups.

While contracting means the home birth associations have to operate within the constraints set out in their purchase of service contracts and have to make compromises, it offers an opportunity to continue the political work of protecting home birth through a bid to gain a more legitimised position for a community group - as service providers - within the health sector. This has become more important as other avenues for political intervention were closed down by the 1991 health reforms. Pursuing contracting can be constituted as a bid to be repositioned as 'inside' the system, where home birth activists can establish personal links to health sector administrators and can be involved in directly configuring services. At the same time, the threat of not being awarded or re-awarded a contract in the next tendering round limits the demands home birth association activists are prepared to make through public avenues such as the media and public meetings.

Conclusion

Anna Yeatman has argued that two very different currents of thought, have converged in a dissatisfaction with 'statecentric modes of power' - the new social movements of socialist, feminist and postcolonial struggles, on the one hand, and the resurgence of liberalism on the other. Both represent:

... a challenge to paternalistic models of power in favour of an alternative model of power which enhances the capabilities of individuals or self-identified groups to govern themselves. Self-government is to be understood to refer to the capacity of these individuals or self-identified groups to practise a self-regulating relationship to their various entanglements in social life (1994:85).

Yeatman argues that there are critical differences between the 'liberal' and the 'new' versions of contractualism. The discourses of contractualism originally come from the liberal model of individuals seeking to maximise their own preferences through the free market (1994:97). In liberal theory, individuals are thought of as either independent and naturally possessing contractual capacity and contractual equality, or as dependent, lacking in contractual capacity and in need of family or state protection (1997:46-47). She argues that present day democracies have been profoundly transformed through accommodating the politics of difference, which the emerging contractualism can not escape (1994:84, 1997:54). In her vision of a 'new contractualism', contractual rights would be extended to those excluded under the liberal framing of contract, and attention would need to be given to the ways in which contractual personhood is socially and relationally produced and can therefore be enhanced (1997:42). Making claims for legitimising alternative subject positions/ identities with respect to contracting can itself be a form of political intervention. Thus, the new contractualism potentially offers ways of extending democratic participation and self-determination.

The home birth associations who enter into tendering for contracts do attempt to combine community based identities with bids to be recognised as possessing contractual capacity. Thus, they are also engaged in trying to negotiate a way in which contractual capacity for community groups should be defined. In this sense, these groups are exemplars of the 'new contractualism' argued for by Yeatman. What is interesting is that different home birth associations do this in different ways. As I argued in the previous chapter, home birth groups involved in contracting have constructed different versions of identity as potential contractual subjects. While the members of the Tauranga Home Birth Association argue that their connection to a grass roots community network is their "biggest asset" (Tauranga Home Birth Association interview, 13 June, 1997), the Auckland and Manawatu Home Birth Associations rely on skills gained through activism and involvement in paid work to support their claims of being able to 'manage' a contract.

Yet, it would appear that home birth associations have had to confront some of the problems of contracting identified by Nowland-Foreman (1998), Higgins (1997) and others. The purchasing authorities, as these writers suggest, do exert considerable control over determining the services that associations will be funded to offer. The home birth associations' experiences of contracting indicate that contractual relationships with funding authorities complicates their operation as consumer oriented health movement organisations. It also changes the relationships between midwives and home birth associations in a number of ways which can potentially create new conflicts as well as new approaches to working in partnership.

This chapter and the previous one also indicate that the opportunities for contracting at any one time are 'contingent'. They depend on relationships with specific health managers and government policies with respect to the

advantages of utilising community networks to deliver health services, encouraging competition at the level of consumer choice or minimising transaction costs through contracts with large providers who can deliver a range of services to the whole population in a given area. The opportunities for home birth associations to enter into contracts are also contingent on the actions of other actors, such as the New Zealand College of Midwives and other providers who might compete for contracts to provide home birth services. This analysis illustrates that, while the introduction of contractualism in the health sector offers new possibilities for some community groups to bid to operate services for their constituencies, it cannot deliver new certainties.

11

Conclusion: standing on a faultline

Maybe we've been too successful. We've made it so easily available - so mainstream that they'll never have to come down from the hills in their battered old cars again. The hairy-legged feminists!

Celia (Auckland Home Birth Association interview, 16 June, 1997)

Introduction

In this concluding chapter, I want to draw together the various strands of analysis which run through this thesis. In responding to the complexities of the maternity sector in the 1990s, home birth associations developed multiple strategies for sustaining collective action. In the face of uniform changes nationally, home birth associations' re-actions have been locally variable. Some groups have tendered for contracts, others attempt to maintain health activism around birthing, while many have become primarily support groups for women choosing to birth at home.

For those activists engaged in forms of public politics, this 'retreat' into

support groups is a sign of the demise of the movement. In the first section of this chapter, I look critically at this position. I suggest that these support groups might be the basis for new political possibilities, as they mirror the interactive communities of home birth associations in the 1970s.

The final section of this thesis examined the tension between contracting and activism. Against the background of this analysis I argue that contemporary home birth associations can be viewed as 'heterarchies' - hybrid organisational forms (Stark 1996). This elasticity may provide a choice of resources to continue to mark out a cultural space for home birth activism in the new millennium.

Cultural politics and state politics

The two major schools of social movement theory offer different approaches to investigating social movements. While the North American resource mobilisation theories concentrate on social movement organisations and political opportunities, the European new social movement theories examine social movements as face-to-face networks in which participants engage in cultural innovation.¹ This apparent dualism between political activism and cultural transformation is replicated in this thesis. I distinguish between action directed at changing government policies and professional organisations, and action oriented towards the production of meanings and practices for childbirth and for mediating the relationships between women and midwives interested in a marginalised birthing option. Like other theorists who combine insights from these two

¹ For collection of key texts in resource mobilisation theory see; McAdam and Snow, eds (1997) *Social Movements, Readings on their Emergence, Mobilization and Dynamics*. For an introduction to new social movement theory see; Cohen, (1985) *Social Research*, Vol. 52, No. 4.

theoretical approaches to studying movements, I use new social movement theory to explain how the movement emerged, while I draw on resource mobilisation theory to account for the interactions between home birth movement activists and the state (see; Laraña, 1994:216; Melucci, 1989:208).

This thesis demonstrates that these 'cultural' and 'political' spheres of action are inextricably linked and intertwined. In the first place, the participants of the early home birth movement constructed meanings and practices for birthing *in relation* to the dominant definitions and practices associated with childbirth. These themselves were products of earlier struggles and conflicts. As home birth was brought to public attention, it became constituted as a symbolic challenge to these dominant representations and 'made visible' the power relations determining hospital childbirth practices. The cultural experimentation and articulation that occurred among midwives and birthing women/ families in the self constituted 'communities' formed by those interested in home birth generated discursive resources to publicly challenge opponents of home birth. At the same time, the political and public debates about home birth recursively shape the meanings movement participants attach to home birth and the significance of collective action. And, paradoxically, the political gains made by home birth movement activists and their success in changing institutional practices has rearranged the field in which home birth occurs. Thus, the meaning of home birth has also changed. In the 1990s, home birth has lost a large measure of its significance as a challenging radical act.

Yet, while the distinction between the cultural and political challenges of the home birth movement continually collapses, we do not want to collapse it entirely. It is because 'cultural practices' can escape the politics of the state at various points that social movements are interesting. Precisely because home birth 'took place' outside the eyes of authorities and elites, home birth

midwives were able to question the limitations of their medically oriented training and consumers and midwives were able to work out more egalitarian ways of mediating professional/ client relationships.

Drawing a distinction between the 'political', defined as engagements with the state, and the 'cultural', as sets of practices constructed through interactions among movement participants, is not confined to debates among movement theorists. In the home birth association networks there has been an uneasy separation between these two lines of action. When the New Zealand Home Birth Association was formed, some participants were wary about the political activism other members pursued. To accommodate these differences, association members decided that: "Therefore we need two parts to our organisation - those who get on with the job of peaceful birthing and those who fight the political battles to protect what the former were doing" (*New Zealand Home Birth Association National Newsletter*, No. 6, 1982:3). This became translated into an organisational form in which many home birth associations separate support meetings from the more externally focussed committee meetings. Other associations concentrate more on support meetings and less on the interface between the association and the state, and vice versa.

Paradoxically, the success of the home birth associations' political activism has not only depoliticised the movement but also 'home birth'. For some long term activists interviewed for this research, this is a 'problem'. On the one hand, they fear countermobilisations by medical interest groups or the cooption of home birth by institutionally based providers who might define home birth only in terms of a 'location,' not a particular kind of practice where women/ families are in control. On the other hand, some long term activists believe that home birth has now become one birthing option from the range of new options for childbirth which have emerged, in part, as a consequence of home birth activism.

Debates continue over home births. In recent government maternity policy statements home birth has been recognised as a legitimate option. The National Health Committee states that: "Home birth is recognised internationally as a safe and appropriate alternative for low risk mothers" (1999:46). At the same time, there have been recommendations from influential sources seeking to limit access to home birth. For example, following the death of a baby after a breech birth at home, the Hamilton District Coroner issued a statement that:

The difficulty before me as I see it stems from the mother's right to free and informed choice and consent insofar as the exercise of that right conflicts with those rights (if any) of the unborn child she carries within her.

In my view the mother has no such right, but it is not for this Court to make such a determination. The creation of new law is a matter for Parliament (Matenga, 1997).²

This poses complex questions for home birth activists. Who should be empowered to decide in which instances the mother's rights conflict with the baby's rights? Who defines which births will be 'low risk'? These issues have been problematic since the home birth movement began and have been the means through which specialists have sought to exercise control over home birth.

Added to this conflict are other concerns for home birth activists. The new professional organisation for midwives could lose its connections to consumer groups if politicised consumers do not stay involved. While

² The evidence presented in Court did not substantiate that the outcome would necessarily have been different if the birth had been planned to occur in a hospital. Using the argument that decisions by parents to attempt home births have put a number of babies lives at risk in recent years, a group of Christchurch paediatricians and obstetricians called for stricter criteria for determining which women should be able to access a home birth service (Malpas, et al, 1997:20; for critical responses, see; Daellenbach, et al, 1997:153, and Richards, et al, 1997:153).

contracting with the Health Funding Authority may offer ways to retain consumer control over home birth services, it demands resources, skills and commitment that are beyond the reach of many home birth associations. Also, the future of direct local contracts is uncertain as the government decides whether to prioritise saving the costs associated with contracting, or to utilise community groups to provide services for those whose needs cannot adequately be met by mainstream providers.

Long term activists are also critical of newer generations of birthing women who no longer face the same struggles to access home birth services, at least in urban areas. As a result, many women who have home births feel less commitment to their local home birth association and may engage more critically with the services they receive. Home birth, one participant suggested, has become a "fashion" (Tilda, individual interview, Christchurch, 31 May, 1998) - a lifestyle choice. Thus, women join some home birth associations and home birth support groups for support for their lifestyle choice, rather than out of a desire to publicly advocate for home birth. What kinds of assumptions underpin this critique? What is excluded by such framings?

When the home birth movement formed, activists sought to persuade politicians and health sector authorities that home birth was not a 'fad' (*New Zealand Home Birth Association National Newsletter*, No. 4, 1981:4). In one of the first articles published about the resurgence of home births, the journalist, Maria Scott, asked all the people she interviewed if they thought that home birth was "just a fad". The women who had birthed at home and the domiciliary midwife, she notes, all said that it was not. By contrast, the obstetrician who was interviewed constructed the new interest in home birth as a "fad that has hit New Zealand ten years after Britain" where, he said the numbers of home births were again decreasing (Maria Scott, *Christchurch Press*, September 25, 1976).

This opposition between 'fads' and 'social movements' also runs through social movement theory (see for example; Tarrow, 1994:3-4; Touraine, 1985:750-751). At the turn of the millennium, this distinction may need to be reexamined.

Contemporary support groups and cultural innovation

Among the home birth groups interviewed, three also functioned as support groups for women who were planning or had planned to birth at home.³ These were the Christchurch Home Birth Association, the Southland Home Birth Association and the Eastbourne Home Birth Support Group. In these groups, almost all of the participants had joined their home birth group within the four years prior to the interview.⁴ These participants represent a new generational cohort of women joining home birth groups. They do so under conditions where they can assume access to home birth services and where home birth is no longer defined in sharp opposition to hospital birth. It is, the interview participants suggested, also not quite 'mainstream' either.

The Eastbourne Home Birth Support Group is based in a small relatively affluent community across the harbour from Wellington. The group members claim that Eastbourne has the highest home birth rate of any area in New Zealand, with one in six babies being born at home. The membership of the group was about 25 women at the time of the interview

³ The interview groups each included participants who had planned a home birth, but had to transfer to hospital before or during labour.

⁴ A midwife participated in both the Christchurch and Southland Home Birth Associations interview groups who had been involved longer, and one woman in the Southland Home Birth Association group had been involved for seven years.

(Eastbourne Home Birth Support Group interview, 6 May 1998). The group organises five meals for families who have planned a home birth, following the birth. Everyone who receives these is expected, in return, to provide five meals for another family at some later date. This group focuses entirely on support. They hold monthly meetings in the evenings in member's homes.

The interview group participants argued that women with babies need support because of their "isolation". This was exacerbated, they suggested, because most women in their community worked in paid employment and took leave to stay at home and mother their babies. As the group participants discussed what 'support' means for them, some interesting points were raised. I will include part of this discussion at length, because the interaction between the participants was important for how their ideas were articulated. For them, 'support' takes a specific form that they argue is not attractive to all women, although it is highly valued by the members. 'Support' means sharing information to give each other options and to enable individual choices about issues connected to childbirth and mothering:

Viv: It's the total support really. Like when I had this one [toddler on her lap], he was getting colic and so all the mothers that were cooking for me, they came round. And they all had children, and they'd say what they found helped and what didn't, and just feeding information, and sharing it and taking what you wanted.

Leonie: But, it doesn't suit some women because it's an open sort of sharing of information - and for some it can sometimes be quite confronting - some of the information that is shared, especially on issues like scans and things like

Viv: and immunisation.

Leonie: And for some women, that's just not suitable for them. And I always try to say "you come take what you want and you decide".

- Sarah: Do we have women who have come along and decide they don't like it and leave?
- Leonie: Yes.
- Nicky: But that's up to the women, like with the immunisation thing. People have strong feelings either way - or they don't. And it's your choice. And it doesn't stop me from coming along.
- Sarah: Yeah, it's your choice.
- Leonie: A lot of other issues seem to come into it. If you're aware of the home birth thing, you're aware of the immunisation thing.
- Viv: That's right
- Leonie: A lot of other people don't like the pressure on the other issues, they just want the birth. And they can go away and take that bit but they don't want the immunisation and the organic food and breastfeeding.
- Nicky: ... And when you make your choice you say "O K, I can choose not to immunise, that's the risk I'll take. Or you choose to immunise and I know that's also a risk I'll take". And you just choose what suits you best and accept the consequences.
- Leonie: It's hard. But when you have the choice, you have it.
- Nicky: It's giving you back the choice as opposed from having it taken out of your hands. But you have to be informed.

(Eastbourne Home Birth Support Group interview, 6 May 1998)

A very similar discussion occurred among the participants of the Southland Home Birth Association interview group. As with the Eastbourne Home Birth Support Group, they have a very active support group. Participants talked about a meeting shortly before the interview where fifty people had attended, including children.

- Rea: What made you want to become part of the association?
- Polly: I think it is probably coming to meetings with a group of women in particular that are prepared to follow their instincts, and challenge the dominant social paradigm, who trust themselves. And suppose I want to learn now from other women who have children that are older than my child, how they are doing it. You know, I sort

- of trust their opinion a lot more than other people.
- Jo: Yes, I would consult people here more than I do my mother. And she parented a lot.
- Polly: And not just home birthing. For me it's not just the fact that there are other women here who have their babies at home or plan to. It's people who are willing to look at things from a different perspective. So we will look at the immunization issue and that comes up for discussion. And when you talk about "so and so has a bad rash or something". Everybody comes up with a homeopathic or natural way to treat it, a whole plethora of stuff. There are so many things. But it's all out of the mainstream. ... It's good to have the support to look at your parenting as well. Because as parents you all try just to do a good job, just in different ways.
- Rea: So how does it work for people who are interested in home birth, but are not interested in alternative things?
- Jo: They probably take what they want. People just take away what they want.
- Daisy: People will just not come back.
- Lillie: I wonder if that's why some who have come, and had a feel for what we're into, don't come back?
- Kate: I think the approach is more like -
- Molly: It's more an encouragement and informed choice.
- Jo: I certainly hope we don't make people feel like they can't be a member because of the choices they make.

These discussions reflect a tension between support for people who engage in practices that might incur mainstream disapproval and support for all women who want or need it. The women who participated in these two discussions expressed appreciation for the group as a 'space' that gives them opportunities for learning, sharing knowledge and feeling 'agency' through discussing options. On the other hand, the comments made above point to a recognition of diversity among home birth consumers. The group participants do not want to exclude women who choose to follow more mainstream practices, but suggest that women who do not like the emphasis on questioning aspects of birthing and mothering may feel excluded.

Versions of these kinds of discussions have possibly always occurred among participants of home birth associations, and the support group organisational form has been part of the movement since it emerged in the late 1970s. However, where in the 1980s these differences were a source of tension in the context of an intensely politicised environment, now they become a resource for those who are members of support groups. The new opportunities offered by the Nurses Amendment Act 1990 for a variety of birthing options give women more space to craft their own, individual definitions of needs and expectations from maternity caregivers. It is less imperative to forge a unified position within home birth associations to fight for common goals. This new generation of home birth women focus on support and solidarity of women who are mothering as opposed to a consolidation of the relationships between midwives and consumers as the agenda of the home birth associations.

Is this a new consumerism? Cindy Patton makes the argument that the new 'lifestyles' of the 1990s are a product of the civil rights campaigns of the 1960s and 1970s (1995:223-229). She argues that in the United States groups deploying rights claims achieved some important political successes, but these occurred within a particular socio-historical context when these kinds of rights claims could be made. The explosion of marginalised groups claiming rights, Patton argues, produced a countermobilisation by the New Right through which civil rights claims have lost their political efficacy. Therefore, we may need to think about how to maintain "the space of "lifestyle" for marginalised groups "without the substantial, but now importantly less accessible, apparatus of civil rights" (1995:226, 241). This provides an interesting way to think about the 'loss of political focus' long term activists talked about in the interviews for this research. While some important political battles have been won, there may still be an ongoing role for home birth associations that focus on support for particular lifestyle choices, support that runs counter to powerful medical discourses and thus

sustains cultural innovation.

Ken Plummer presents a different account of these issues. He argues that there may be a change in the contemporary politics of 'Western-style nations' and indicates that a new 'realm of citizenship' is emerging. In addition to the classic rights to "justice, political representation and basic welfare", a new right to "intimate citizenship" is being asserted. These rights are:

... concerned with all those matters linked to our most intimate desires, pleasures and ways of being in the world. ... Now, and I suspect increasingly in the future, people may have to make decisions around the *control (or not) over* one's body, feelings, relationships; *access (or not) to* representations, relationships, public spaces, etc.; and *socially grounded choices (or not) about* identities, gender experiences, erotic experiences (1995:151).

Earlier generations of home birth activists resisted being "obedient and willing subjects of the state" authorised maternity services. In doing so they carved out a space wherein new generations of childbearing women could become "skilled and eager consumers" (Bauman, 1992:17), exercising choices with respect to birthing care and a multitude of other aspects of mothering. These women may not be as overtly political, but at the same time the political opportunity structure has changed. This raises interesting questions about what new forms of politics might - or might not - emerge from the 'support groups'.

Diversity, uncertainty and organisational 'hedging'

In the 1990s home birth associations have been challenged to remake themselves to continue to operate in a new environment. They have been

affected not only by major shifts in policy but also in policy making processes. While many of the opportunities for direct participation in decision making that were created in the late 1980s have closed, new opportunities have opened for home birth associations to become providers of home birth services. Home birth associations that were once clearly defined as home birth political advocates and information and support networks for domiciliary midwives and women/ families who chose to birth at home, now potentially enter into more complex relationships with the state.

Members of the Christchurch Home Birth Association interview group suggested that their association had many roles. One included holding an antenatal class contract with a health funding authority and employing members to facilitate antenatal classes. Also mentioned was the importance of providing information resources for members that presented "different options, outside the direct medical field", and "support for women who choose to birth at home". This led to reflections on the 'watchdog' role of home birth associations:

Tui: And isn't it also not to get complacent about home birth as a choice? And people knowing what's going on politically in terms of health and all the things that are happening there at the moment ... and working with midwives - and keeping midwives honest as well.

[general laughter]

Jackie: Watchdog, I think it is that thing of - apart from that active stuff that you do by being part of standards review committees and Polytech selection committees and the College. And putting in submissions and letters to editors and all that sort of thing. But the fact that the associations exists as a watchdog in itself - the fact that there is a group who believe that there are enough issues for there to be a group - that it's an ongoing thing and it hasn't gone away. It isn't going to go away!

(Christchurch Home Birth Association interview, 25 Sept, 1997)

Home birth associations that reposition themselves as service providers do this in ways that resist definitions of commercially oriented provider groups. David Stark, writing about the postsocialist firm in Eastern Europe uses a term 'heterarchy' to explain the unique organisational structure of these firms (1996:20-26). He argues that in the new postsocialist context, firms are pushed to enter the market, but as they reorganise themselves to enter into market relations, they keep aspects of previous forms of organisation. This, Stark argues, gives them flexibility to meet the demands of highly uncertain political and regulatory environments (1996:20, 24-26). Similarly, home birth associations that enter into contracts do not entirely remake themselves as competitive business enterprises. They do not exist to fulfil commercial goals, but to provide political and emotional support for those who want to birth at home. Home birth associations in the 1990s, in a similar way to the postsocialist firm, display organisational flexibility. They exhibit what Stark has referred to as:

... [A] form of organizational hedging ... in which actors respond to uncertainty in the organizational environment by diversifying their assets, redefining and recombining resources (Stark, 1996:7).

We cannot tell a teleological story about the success of the home birth associations. They have neither been repositioned as interest groups inside the polity, nor as a consequence of their success, have the associations died out, although many are struggling to keep an active membership. At the end of the 1990s these associations continue to defend the practice of birthing at home and support women and their families preparing to activate this birthing option. While the discourses that informed the relationship between domiciliary midwives and birthing women are no longer radical on the cusp of the new millennium, the choice of home birth still generates debate. Home birth associations continue to provide an

organisational sphere within which a marginalised practice is supported.

At the same time, as organisational hybrids they incorporate the business acumen of small contractors and respond to shifts in health policy. As consumers of midwives' services they are also constantly negotiating their relationship to individual midwives and to the New Zealand College of Midwives. This involves sustaining the discursive construction of 'partnership' while also confronting the power of midwives as a professional group. These challenges are experienced in the context of limited financial resources, a decline in institutional memory and uncertainty about new midwifery provider organisations. In this context the hybridity of home birth associations is both a potential source of tension and a significant resource.

Appendix I

The interview groups

Everything Has to Be Somewhere. The import of everything being somewhere is that what you are studying is taking place somewhere specific. Not in the world in general, or in "a social setting," but in this place, right here, and whatever is true of this place is going to affect it (bold in original) (Becker, 1998:56).

This appendix provides descriptions of the home birth associations selected for interviews and signals why each one was chosen.

Tauranga Home Birth Association

Tauranga is a city in the Bay of Plenty with a population of close to 83,000. This is one of the fastest growing population areas in New Zealand, with a significantly higher proportion of elderly and children under 15 than the national rate (Department of Statistics, 1999). The interview participants from the Tauranga Home Birth Association described it as an area with great disparities between the rich and the poor (25 March, 1997). Members of the association come from both the urban area of Tauranga and the rural outlying areas. The wider mid-North Island area which includes the Bay of Plenty has a significantly higher rate of home births than the national average (Performance Management Unit, 1997:77-78).

The Tauranga Home Birth Association was one of the founding branches of the New Zealand Home Birth Association in 1981. Although for much of the 1980s there were no domiciliary midwives based in the area, the association managed to maintain a membership. A woman who had been

involved in the Christchurch Home Birth Association in the early to mid-1980s described the members of the Tauranga Home Birth Association as follows: "They were so strong. I remember them coming [to conferences] with their prams on top of the vans" (Tilda, Individual interview, Christchurch, 31 May, 1998).

The first interview I conducted was with members of the Tauranga Home Birth Association, in March, 1996. This gave me an opportunity to refine the kinds of questions I might ask and do a trial analysis. Three women participated, two consumers and one home birth midwife. All three had been involved in the association since before 1990. Two other people were expected but did not attend. The interview lasted two and a half hours. I chose this group for a pilot because they held a contract to provide free antenatal classes and home help for women/ families/ whānau choosing to birth at home. This provided material for a trial analysis of contrasting the Tauranga Home Birth Association activists' views on contracting with that from my knowledge of the Christchurch Home Birth Association critiques of contracting. These differences in positions had become less distinct by the time I conducted an interview with members of the Christchurch Home Birth Association, but this was a good way to work out how I might shape an analysis.

In this interview I began by asking participants how they became involved with the association and what their 'philosophy' of childbirth was. These questions produced long and involved answers. What was interesting was that the accounts were very individualistic and different from each other. This was a sharp contrast to the rest of the interview where, as can be seen from the excerpts used in later chapters, the participants shared understandings of the issues in question. Consequently, in the following interviews, apart from the last two, I did not ask these questions. In the final two interviews with the Eastbourne Home Birth Support Group and the

Southland Home Birth Association, I reintroduced the question about how participants had become involved in the group. In part this was because most of the participants in these interview groups were relatively new and this was a story they could tell. More importantly, as my analysis progressed, I became interested in the ways in which women were drawn into home birth networks.

After I had revised the questions I wanted to ask in the interviews, I arranged a second interview with members of the Tauranga Home Birth Association in June, 1997. One woman, who had joined within the last year wanted to participate in the interview but was unable to do so because her children were ill. I met her for an individual interview in the morning. The group interview in the afternoon did not work out very well. Before the interview, the three participants and I met for lunch across the street from the home birth rooms where the interview was to take place. As we were crossing a main road to go to the interview site, one woman and her toddler were almost hit by a car that came out of a side street at high speed. Only the quick actions of another member who leapt forward to forcefully push them out of the way saved them, the braking driver bringing his car to a stop about a metre past where they would have been walking. Witnessing this near accident, I thought they had all been hit by the car. We all found it difficult to recover from the shock to focus on the interview. This interview lasted three quarters of an hour and was terminated when none of us could remember which questions had been covered. Unfortunately I had to leave the next morning and could not reschedule the interview.

Manawatu Home Birth Association

Like most of the associations I chose to interview for this research, the Manawatu Home Birth Association was one of the original branches of the New Zealand Home Birth Association. The Manawatu Home Birth Association is based in Palmerston North, a city of 74,000 inhabitants, two hours drive north of Wellington. I was interested in interviewing members of this association because they had managed to negotiate a contract with the Central Regional Health Authority to provide a complete home birth service including paying for the antenatal, birth and postnatal midwifery care.

The interview took place at the house that the association, through the trust that manages the contract, rents near the centre of Palmerston North. This house is blue with a mural and the name of the trust - Community Birth Services - painted across the front. Initially six women came for the interview. One, a midwife, had to leave and another woman went to look after the children from a La Leche League meeting that was taking place in the main room of the house.

Two of the interview participants had been involved since before 1990, while the other two had joined within the previous two years. Each had a baby or a toddler present during the interview. In my diary notes, I recorded that:

People talked easily, enthusiastically, obviously used to discussing in groups, managing differences of opinion, rarely talking over each other, though rapidly picking up if someone seemed to run out of things to say. I felt comfortable with asking challenging questions (24 March, 1997).

The interview lasted one and a half hours and we covered all the interview

questions.

After the interview, I accompanied a couple of the interview participants to the Palmerston North Hospital where they had been invited by a manager to view and comment on the architectural plans for renovations of the maternity unit. This underscored what been said in the interview - that holding a service contract had made the Manawatu Home Birth Association/ Community Birth Services Trust more visible to other health service providers. Interestingly, although they were perhaps consulted because they were providers, their feedback in the meeting, I noted, was asked for as consumer representatives.

Wellington Home Birth Association

My interview with members of the Wellington Home Birth Association was the only interview that took place at night and where no children were present. Six women participated in the interview. Three who had been involved since the early 1990s, one from before that, and two who had joined within the previous year. One of the participants was a student midwife. One woman came from the Eastbourne support group. She suggested that I should also arrange an interview with the Eastbourne Home Birth Support Group.

The Wellington Home Birth Association is divided between the committee that is responsible for the newsletter, library and hire equipment for home births (for example birth pools), political lobbying and representation on New Zealand College of Midwives committees and other agencies that ask for a home birth consumer representative. In the 1980s, this Association were also politically oriented, but in the 1990s concentrate on providing

services to their members. Around the greater Wellington area, there are several support groups, which come and go. These are connected to the Association through sending representatives to committee meetings and receiving the newsletter.

This interview was the most structured of all the interviews I conducted. This, I think, was because there were no children present and this group have a 'culture' of more structured meetings. I found at some point that group members took a facilitator role, checking the sheet of questions to move on to the next one, or asking someone for clarification of something they had said.

Auckland Home Birth Association

The Auckland Home Birth Association started the formal organisations of the home birth movement in New Zealand in the late 1970s. This association has always been very politically oriented and operated as the key strategist for the movement in the 1980s. Auckland is the largest city in New Zealand with a population of one million. There have been about 400 home births a year in Auckland during the 1990s. The Auckland Home Birth Association has a very large membership, but a small active committee. Like Wellington, the Association is separate from a network of support groups. However, none of these was active when I went there to conduct an interview.

Only two women participated in the interview. Both were long term activists with a detailed knowledge of the history of home birth politics and also the processes for political interventions and the complexity of the numerous statutory arenas responsible for maternity services policy making and

delivery. These members of the Auckland Home Birth Association committee have close ties to other feminist health activist groups and maternity consumer groups in Auckland. They are also actively involved with the New Zealand College of Midwives. The interview took place in the morning at the Auckland Home Birth House. This house has a large open space for meetings and is used as a clinic by several home birth midwives. The interview lasted one and a half hours, and I left it exhausted from concentrating on taking in so much information.

While I was in Auckland, I also spent many hours researching Joan Donley's media, meeting minutes, letters and submissions files. She was available to answer my questions and fill in the information that was not contained in the written texts. This gave me a rich picture of the 'herstory' of the home birth movement.

Christchurch Home Birth Association

Christchurch, where I live, is the largest city in the South Island. The Christchurch Home Birth Association committee engages in both politics and support, although over the last few years, this is organised through separate meetings. I am currently the longest standing member of the Association committee, although during the time of working on this thesis I attend meetings sporadically.

I had the most anxiety about this interview, because I was not sure how to negotiate the contradictions between my insider/ researcher statuses. In the interviews with other associations, I was in a sense an outsider of their particular group. In relation to the Christchurch Home Birth Association, I was not only a member, but also the key holder of the institutional memory

of the organisation. I considered asking someone else to facilitate the interview and discussed this at a committee meeting. The other committee members present felt that this was unnecessary. It was interesting in the interview - the participants treated me as an interviewer, not a committee member. As in the other interviews, in my introductory 'talk', I explained that my approach to writing the thesis was that I would directly use their comments and in this interview I showed the participants an example of what the text would look like. This may have helped them to reposition me as an interviewer rather than an 'insider'.

Seven women and almost twice as many children attended the interview. The conversation was rapid and newer members used it as an opportunity to ask others lots of questions about the arguments they were putting forward. The interview took two hours.

Dunedin Home Birth Association

Dunedin is the second largest city in the South Island with 112,000 people. It has a university and consequently has a high student population. It was one of the original branches of the New Zealand Home Birth Association. I was interested in interviewing members of the Dunedin Home Birth Association because similarly to the Christchurch Home Birth Association they had not been initially interested in contracting. However, they tendered for an antenatal class contract in 1996. Also, when the Bachelor of Midwifery degree started in Otago, many students became involved with the association and I was interested in how the consumer members felt about this. However, this was no longer the case by the time I conducted the interview

To say that this interview did not go as planned is an understatement. I was going to attend a half-yearly regional meeting in Dunedin on behalf of the Christchurch Home Birth Association. I contacted a member of the Dunedin Home Birth Association to see if it would be possible to arrange an interview on one of the days before or after the meeting. This was not convenient, which was not a problem because Dunedin is only four hours drive from Christchurch. However, my contact person suggested that I should do an interview at the regional meeting. I was not sure if this was a good idea because I could not inform people beforehand to give them time to consider participation, and I was not happy about this crossover between my activist and researcher roles. Over subsequent calls my contact person grew more enthusiastic about the idea. I brought down information letters, consent forms and questionnaires, and thought of questions, deciding I would check it out at the time to see if an interview was appropriate.

As it turned out, only one other person from outside of Dunedin, a representative from the Southland Home Birth Association, came to the meeting. Eight women were present. Everyone was glad that I could do an interview and give this meeting another purpose. After about half an hour, the woman from Southland had to leave because she was unwell. The interview proceeded with participants suggesting that this could be my interview with their association. This, they pointed out, would save me a trip and save them time also. However, I had not put any thought into the questions for the Dunedin group because I had not expected to do the interview at this time. All these factors combined to make this a less than optimal interview situation

A key insight I gained through this interview was that I was neglecting the support role of associations by focussing on their political, externally oriented activities. I subsequently decided to follow up on the suggestion

made by a member of the Wellington Home Birth Association to conduct an interview with the Eastbourne Home Birth Support Group.

Eastbourne Home Birth Support Group

Eastbourne is a small, affluent community across the harbour from Wellington. It has the highest rate of babies born at home of any area in New Zealand. Members from the Eastbourne Home Birth Support Group estimate that one in six births in Eastbourne are home births. It also has an active support group which provides meals for families following a planned home birth (even if a woman has to transfer to a hospital for the birth). This group was established in 1991.

Four women and their children attended the interview, which was held at the house of one of the members. The interview was held in the morning and lasted an hour and twenty minutes. Conversation flowed easily. It emerged through their discussions that all the women in this group were in heterosexual relationships. This is the only group, except the Christchurch Home Birth Association, about which I know this information. However, I suspect that all the other groups may have included at least one single mother. In the Christchurch Home Birth Association interview group, three of the seven participants were single mothers. No women identified as lesbian in any of the interview groups.

This interview showed me another 'politics' which I had not come across in any of the other interviews. Instead of investing in the politics of the state and the politics of professionalisation, these women were interested in a politics of mothering and woman to woman support networks. This expanded on the discussions amongst members of the Dunedin Home Birth

Association interview group. However, while the association members from Dunedin were struggling to establish support groups, the women in Eastbourne had a thriving group.

Past member of the Christchurch Home Birth Association

I wanted to arrange an interview with a group of women who had been involved in the early years of the Christchurch Home Birth Association. I was interested in exploring issues of change and continuity in the association and the home birth movement. This interview proved to be difficult to organise, primarily because I could not locate a group of women who were still continuing to keep in contact with each other. The first women I approached no longer had connections with the other women who had been committee members at the same time. I spoke to a second early member of the Christchurch Home Birth Association who thought she could organise a lunch meeting for me to conduct an interview.

This contact person contacted me a couple of months later and explained that she had concerns about who to approach and difficulties in locating some of the women who she thought might be interested. However, she had given the broad questions I had outlined for her in our first conversation a lot of thought. These included questions about change in the movement over the last two decades, and the differences between home birth associations. As we talked, I decided to conduct an individual interview with her. The rationales for group interviews did not apply so clearly in a situation where women had left the group and were no longer engaged in producing a collective identity with a collective investment in how they represented themselves to others. This became the interview with 'Tilda'.

Southland Home Birth Association

Southland has an active home birth association, with two branches, one in Invercargill and one in Gore. These take in large rural areas. The Southland Home Birth Association was formed in 1986. There are three midwives who attend home births in Southland and about 30 home births annually. In the interview, participants described Southland as 'conservative' and 'remote'. Nonetheless, the Southland Home Birth Association has sent representatives to almost all the home birth conferences in the 1990s and members have been active in writing submissions in response to various policy documents.

One of the reasons I was interested in interviewing this group was because they have not been involved in contracting. In 1998, this changed as the group decided to try to secure a contract with the Health Funding Authority to provide home help. They had in the past received a grant from a private trust to provide this service. Their tender application had not been accepted and the response they had from state officials was interesting in itself.

I took my family to this interview and we stayed on the farm of my contact person. It was in spring, during lambing, with daffodils and blossom everywhere. Eight women, one man, and twice as many children came to the interview, which was held at the home of the contact person. A number of these participants only came to the social support meetings that are held by the Association, rather than being committee members. The committee members also attend the support meetings.

The interview was two and half hours long because I asked each participant how they became involved and discussions around this question took an

hour and a half. It was, however, instructive in showing me how I could have done this thesis quite differently if my focus had been an ethnography of the home birth associations. Participants talked about birth, transfer to hospital, their difficulties in accessing home birth and the importance of the support group. After the interview, everyone stayed for a pot-luck lunch, and some even stayed for dinner. It was a wonderful way to close the information collection stage of the research process.

Appendix II

Interview question guides

Manawatu Home Birth Association interview

10 am, 24th March 1997

1. In what ways has the focus of your home birth association changed and in what ways have you maintained continuity over the last five years?
2. How has holding a service contract affected other areas of home birth association activism?
3. Tell me about Community Birth Services, the trust board and how it was set up? Could you tell me about the negotiations, how you ensured you got what you wanted and what things you had to compromise on?
4. How did you address Treaty issues in your contract? What do you do with respect to Treaty issues as an association?
5. What is your relationship to the local independent midwives and the NZCOM?
6. How has your contract been received by the CHE?
7. How would you describe your relationship with the Central Regional Health Authority?
8. Does your home birth association have formal and/or informal connections with other community/ health/ maternity groups?
9. How do you see your group in comparison to other home birth groups?
10. What impact, if any, have the Nurses Amendment Act and the 'health reforms' had on your association?

Wellington Home Birth Association interview

7:45pm, 25th March 1997

1. Do you think that the focus of your home birth association has changed in the last five years? If so, in what ways?
2. Could you please tell me about what your group does and the internal dynamics and structure of your group? Is the support network still active?
 1. Relationship to business of Wellington Home Birth Association core group.
 2. Is there a contact or support group for Maori home birth families? What have you done or are you doing about issues of Treaty partnership?
 3. How do you maintain this network - encourage people to come?
3. What is your relationship to the local independent midwives?
 1. What is your relationship to the Wellington Region of the New Zealand College of Midwives?
 2. How is the Midwifery Standards Review Committee operating in this area and what is your input?
4. As I understand it - your group has discussed/ considered but not tendered for an RHA contract. I'm sure there must be a whole host of reasons for this. Could you elaborate on these?
 1. Can you tell me a bit about the Central Regional Health Authority policy relating to contracting for maternity services?
 2. Last year you tried to get the transfer protocols at Wellington Hospital changed. What has happened with that and what have you learned/worked out about how to lobby CHE?
5. Does your home birth association have formal and/or informal connections with other community/health/maternity groups?
6. How do you see your group in comparison to other home birth groups?
7. What impact, if any, have the Nurses Amendment Act and the 'health

reforms' had on your association?

Auckland Home Birth Association interview

9:30 am, 16th June 1997

1. In what ways has the focus of your home birth association changed and in what ways have you maintained continuity over the last five years? What impact have the Nurses Amendment Act and the 'health reforms' had on your association?
2. Why did you decide to tender for a contract? What do you hope will be the benefits? What do you think might be the problems or disadvantages with holding a contract? What impact do you envisage holding a contract will have on the Home Birth Association?
3. How have you dealt with 'Treaty' issues in your contract? Do you have links with Maori providers?
4. What is your relationship to the local independent midwives and the NZCOM?
5. How would you describe your relationship with the Northern Regional Health Authority?
6. How has your contract been received by the CHE?
7. Does your home birth association have formal and/or informal connections with other community/ health/ maternity groups and how are these significant?
8. How do you see your group in comparison to other home birth groups?

Tauranga Home Birth Association interview

1 pm, 13th June 1997

1. In what ways has the focus of your home birth association changed and in what ways have you maintained continuity over the last five years?
2. How has holding a service contract affected other areas of home birth association activism?
3. Tell me about the trust home birth board and how it was set up? Could you tell me about the negotiations, how you ensured you got what you wanted and what things you had to compromise on?
4. How have you dealt with 'Treaty ' issues in your contract? Do you have links with Maori providers?
5. What is your relationship to the local independent midwives and the NZCOM?
6. How has your contract been received by the CHE?
7. How would you describe your relationship with the Midlands Regional Health Authority?
8. Does your home birth association have formal and/or informal connections with other community/ health/ maternity groups?
9. How do you see your group in comparison to other home birth groups?
10. What impact, if any, have the Nurses Amendment Act and the 'health reforms' had on your association?

Christchurch Home Birth Association interview

1 pm, 26th September 1997

1. What do you consider are the most important roles for the Christchurch Home Birth Association?
2. How do you see your group in comparison to other home birth groups? What do you identify as distinctive about home birthers and the home birth association?
3. Does your home birth association have formal and/or informal connections with other community/ health/ maternity groups and how are these significant?
4. What have you done or are you doing about issues of Treaty partnership?
5. In what ways has the focus of your home birth association changed and in what ways have you maintained continuity over the last five years?

South Island Home Birth Associations half-yearly meeting

11 am, 25 March, 1998

1. How - and when - did you become involved in your home birth association?
2. What does your group do for women who are considering - or have had - a home birth? (e.g. birthing equipment, library, antenatal classes, support group, monitoring and lobbying, an so on)
3. Meetings - what happens at your meetings? What kinds of meetings do you have, how often , when, and who comes along?
4. What is your relationship to the independent and home birth midwives in your area? How are the Midwifery Standards Review Committees operating in this area and what is your input?
5. Has your group considered - or taken up - tendering for an RHA contract to

provide some aspect of a home birth service? What issues came up? What have your experiences been?

6. How do you see your group in comparison to other home birth groups? And in comparison to other groups you have connections with in your area?

Eastbourne Home Birth Support Group

10 am, 6th May, 1998

1. How - and when - did you become involved in this support group?
2. What does your group do for women who are considering - or have had - a home birth? (e.g. birthing equipment, library, antenatal classes, support group, monitoring and lobbying, and so on)
3. Meetings - what happens at your meetings? What kinds of meetings do you have, how often , when, and who comes along?
4. What are your connections to the Wellington Home Birth Association?
5. What is your relationship to the independent and home birth midwives in your area? How is the Midwifery Standards Review Committee operating in this area and what is your input?
6. Has your group considered - or taken up - tendering for an RHA contract to provide some aspect of a home birth service? What issues came up? What have your experiences been?
7. How do you see your group in comparison to other home birth groups? And in comparison to other groups you have connections with in your area?

Southland Home Birth Association

10:30 am, 6 October, 1998

1. How - and when - did you become involved in your home birth association?
2. What does your group do for women who are considering - or have had - a home birth? (e.g. birthing equipment, library, antenatal classes, support group, monitoring and lobbying, and so on)
3. Meetings - what happens at your meetings? What kinds of meetings do you have, how often , when, and who comes along?
4. What is your relationship to the independent and home birth midwives in your area? How is the Midwifery Standards Review Committee operating in this area and what is your input?
5. Has your group considered - or taken up - tendering for an RHA contract to provide some aspect of a home birth service? What issues came up? What have your experiences been?
6. How do you see your group in comparison to other home birth groups? And in comparison to other groups you have connections with in your area?

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